

Eurofins Biomnis, Blackthorn Road, Unit 3, Sandyford Business Centre, Sandyford Business Park, Dublin 18, D18 E528,
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 Packaging instructions: <https://www.eurofins.ie/eurofins-lablink/packaging-transportation-guidelines/>

REQUESTING PHYSICIAN - PLEASE USE BLOCK CAPITALS

Please note all the fields are **MANDATORY** - Ensure to complete the fields with the **SAME DETAILS** registered in our system
 If you are unsure of your details, please contact our Client Services (clientservices@ctie.eurofinseu.com) team for advice
 Failure in properly completing the form may result in sample rejection

Location Code (if applicable): _____ Doctor code (if applicable): _____
 Physician name: _____
 Clinic name: _____
 Address: _____
 Telephone: _____ Fax: _____ Email: _____

PATIENT DETAILS

If you have a sticker with the patient details, please stick it below instead of writing/typing them
 Please note all the fields are **MANDATORY**. Failure in properly completing the form may result in sample rejection

Surname: _____
 First Name: _____
 DOB: ____/____/____
 Address: _____
 Telephone: _____ Email (if applicable): _____

CLINICAL DETAILS

Please include any signs and symptoms, previous abnormal cytology, diagnosis and treatment

TESTS REQUESTED

	PRICE
Cervical cytology (Thinprep PAP Test) and High Risk HPV DNA combined tests - HPVNL	€100

CLINICAL DETAILS

LMP: ____/____/____
 Last Smear Test: ____/____/____

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Menopausal | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Irregular bleeding |
| <input type="checkbox"/> Post Menopausal | <input type="checkbox"/> IUCD in situ | <input type="checkbox"/> Discharge |
| <input type="checkbox"/> Post Natal | <input type="checkbox"/> O/C | <input type="checkbox"/> Suspicious cervix |
| <input type="checkbox"/> Cervix Visualised | <input type="checkbox"/> 5 rotations | <input type="checkbox"/> Vault |

Please Provide Details

Smear Taker Signature

EUROFINS BIOMNIS USE ONLY

Sample Collection Date: ____/____/____

Payment Options - Please select ONE of the below:

- Our surgery/GP has an account with Eurofins Biomnis: Please tick the box & enter your account code here:
- Cheque - Please tick the box and include the cheque with the sample