Accr.Nr: 157
EN/ISO 15189

Laboratory Genetic Metabolic Diseases

Test request form Metabolite / Tumor diagnostics

Academic Medical Center
Lab. Genetic Metabolic Diseases (F0-132)
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Website: www.labgmd.nl

Dr. F.M. Vaz – clinical biochemist IEM
Dr. S.M.I.Goorden – clinical biochemist, fellow IEM
Dr. W. Kulik – clinical laboratory geneticist

To assure correct handling of your request, please fill out this form completely (Grey fields are mandatory) and send it in together with the sample(s).

Patient information

Family name : ....
First name : ....
Date of birth : Day: .... Month: .... Year: ....
Sex : Male/Female

Requested test(s) (see www.labgmd.nl)

Disease and/or analysis : ....

Material*

For metabolic screening always at least send urine and EDTA blood

						yes	no
☐ **Urine**	collection date..........	collection period..........hrs	volume..........ml		crisis	☐	☐
☐ **Blood**	sampling date..........	time..........	☐ heparin	☐ EDTA	deproteinized	☐	☐
☐ **Plasma**	sampling date..........	time..........	☐ heparin	☐ EDTA			
☐ **Serum**	sampling date..........	time..........					
☐ **Bloodspot**	sampling date..........	time..........					
☐ **CSF**	sampling date..........	time..........			deproteinized	☐	☐
☐	sampling date..........	time..........					
☐ **Tissue**	sampling date..........	specify..........					

*Please send urine, plasma, CSF and tissues on dry ice, whole blood at ambient temperature, all by courier.

Relevant clinical and laboratory findings and medication

Results should be sent to

Name	: ....
Department	: ....
Hospital/institute	: ....
Address	: ....
City and Zip-code	: ....
Country	: ....
Phone	: ....
Fax	: ....
E-mail*	: ....

** Results will be sent per email when fax is unavailable, unless disagreed.* ☐ No

Copy results should be sent to

Name	: ....
Department	: ....
Hospital/institute	: ....
Address	: ....
City and Zip-code	: ....
Country	: ....
Phone	: ....
Fax	: ....
E-mail	: ....

Invoice should be sent to*

Name	: ....
In case of institution	
Department	: ....
Hospital/institute	: ....
Address	: ....
City and Zip-code	: ....
Country	: ....

** For EU countries only: Original S2 forms (formerly E 112) should be filled out completely and can be sent in together with the sample(s) or separately.*

Form completed by

Name	: ....
Function/Department	: ....
Date	: ....
Signature	: ....

Please note that without the above requested information the requested test(s) cannot be performed.

Use this as address label

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1105 AZ Amsterdam

The Netherlands

DIAGNOSTISCH MATERIAAL

SPOED!

INSTRUCTIONS

- Please use the test request form that applies:
- 1) metabolite/tumor-, 2) enzyme-, 3) DNA-diagnostics.
  See www.labgmd.nl/forms
- To assure correct handling of your request, please fill out the test request form completely **in English** and send it together with the sample(s). Grey fields are mandatory.
- Please include copies of all relevant correspondence with our laboratory concerning the request.
- In case of urgent requests (e.g. prenatal testing) please contact a staff member of the laboratory BEFORE sending the sample.
- Our laboratory is open on working days Monday to Friday from 8.30 AM to 5.00 PM. Our website www.labgmd.nl lists national holidays on which our laboratory is closed.
- Please make sure that sample(s) arrive on Monday to Thursday before 3 PM, on Friday and the day before a public holiday before 12 AM. Otherwise we cannot guarantee that we can process the samples appropriately.
- For test-specific information about material/shipment please visit our website www.labgmd.nl