CONFIDENTIAL DOCUMENT
INFORMATION RELATED TO THE PATIENT'S MEDICAL CONDITION

eurofins | Biomnis

Clinical Information Form
Sperm DNA fragmentation Test SCSA

INTERNATIONAL DIVISION

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☐ **URGENT**

Hospital or laboratory identification

Stick your laboratory ID sticker here

REFERRING LABORATORY

Name: .....
Address: .....
Post Code: ⌊_⌊_⌊_⌊_⌊_⌋ City: .....
Country: .....
Tel.: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋ Fax: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋
Contact: .....

PATIENT DETAILS

First name(s): .....
Surname: .....
Your reference: .....
Date of birth: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌊_⌊_⌋

Address: .....
.....
Post code: ⌊_⌊_⌊_⌊_⌊_⌋ City: .....
Country: .....

CLINICIAN

First name(s): .....
Surname of physician: .....
Address: .....
Post code: ⌊_⌊_⌊_⌊_⌊_⌋ City: .....
Country: .....

OBLIGATORY INFORMATION REGARDING SPERM SAMPLE

Sperm count: ..... 10^6/ml
Vitality: ..... %

Referral date: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋

Frozen on (date): ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋

Number of frozen aliquots (at least 2): ⌊_⌊_⌋