CONFIDENTIAL DOCUMENT
INFORMATION RELATED TO THE PATIENT'S MEDICAL CONDITION

Biomnis

Clinical Information Form
Infectiology

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PRESCRIBING CLINICIAN OR REFERRING LABORATORY

PRESCRIBING CLINICIAN

Name: ....
Hospital/ward: ....
Tel.: __ __ __ __ __
Fax: __ __ __ __ __
Email address: ....

REFERRING LABORATORY

Name : ....
☐ Hospital ☐ Private Laboratory
Address/Country: ....
....
Tel.: __ __ __ __ __
Fax: __ __ __ __ __
Email address: ....

PATIENT DETAILS*

First name(s): .... Surname: ....
Maiden name: ....
Date of birth: __ __ ____ Gender : ☐ M ☐ F
Address/Country: ....

**This information is compulsory to proceed with testing.*

SAMPLE

Sample type: ....
....

Sample date: __ __ ____

CLINICAL SYMPTOMS

Clinical onset date: __ __ ____

Nature of clinical signs

☐ Digestive ☐ Renal ☐ Ocular
☐ Respiratory ☐ Urogenital ☐ Lymph node
☐ Cardiac ☐ Neurological ☐ Muscular
☐ Cutaneous ☐ Articular ☐ Others: ....

Evolution: ....

CLINICAL DETAILS

Time between the clinical onset and the sample date: ___ days
History: ....
Immunodepression: ☐ YES ☐ NO Pregnancy: ☐ YES ☐ NO
Recent trip (specify the country): .... D D M M Y Y
Contact with an animal (specify details): .... D D M M Y Y
Arthropod sting or bite (specify): .... D D M M Y Y
Contact with still water (specify): .... D D M M Y Y
Others: ....
Vaccination: ....

THERAPEUTIC

Date of treatment: ....
Nature: ....

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