CONFIDENTIAL DOCUMENT
INFORMATION RELATED TO THE PATIENT'S MEDICAL CONDITION

eurofins | Biomnis

Clinical Information Form
Inhibin A

Completed form must be attached with the sample.

INTERNATIONAL DIVISION

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PRESCRIBING CLINICIAN/REFERRING LABORATORY

Clinician's Email: .....

Name of Clinician: .....

Dept/Ward: .....

Address: .....

.....

Post code: ⌊_⌊_⌊_⌊_⌊_⌋ City: .....

Country: .....

PATIENT DETAILS

First name(s): .....

Surname: .....

Date of Birth: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌊_⌊_⌋

Gender: ☐ F ☐ M

Sample Date: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌊_⌊_⌋

REASON FOR TEST REFERRAL

- **MENOPAUSAL WOMAN:** ☐ YES ☐ NO

  If not, please specify the date of the last menstrual period: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌊_⌊_⌋

- Additional Information: .....

  .....

- **TUMORAL CONTEXT:** ☐ YES ☐ NO

- Have other tumoral markers already been tested? ☐ YES ☐ NO

  If yes, which tests and what were the results: .....

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- Additional Information: .....

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- **ULTRASOUND INFORMATION:** .....

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These tests are subject to referral.

R38-INTGB - June 2020