CONFIDENTIAL DOCUMENT
INFORMATION RELATED TO THE PATIENT'S MEDICAL CONDITION

eurofins | Biomnis

Clinical Information Form
SEROLOGY COVID-19 (SARS-CoV-2)

INTERNATIONAL DIVISION • Tel.: +33 (0)4 72 80 23 85 • Fax: +33 (0)4 72 80 73 56 • E-mail: serviceexport@eurofins-biomnis.com

PRESCRIBING CLINICIAN AND/OR REFERRING LABORATORY

REQUESTING PHYSICIAN

First name(s): .....
Surname: .....
Name of hospital: .....
Address: .....
Post code: |_|_|_|_|_|
City: .....
Country: .....

Tel.: |_|_| |_|_| |_|_| |_|_| |_|_|
Fax: |_|_| |_|_| |_|_| |_|_| |_|_|

REFERRING LABORATORY

Surname: .....
Address: .....
Post code: |_|_|_|_|_|
City: .....
Country: .....
Department/ward: .....
The telephone and fax number of the requesting department/ward is ESSENTIAL in order to send patient results quickly.
Tel.: + |_|_| |_|_| |_|_| |_|_| |_|_| |_|_|
Fax: + |_|_| |_|_| |_|_| |_|_| |_|_| |_|_|

PATIENT DETAILS

First name(s): ..... Surname: ..... Birth name: .....
Address: .....
Post code: |_|_|_|_|_| City: .....
Country: ..... Tel.: |_|_| |_|_| |_|_| |_|_| |_|_|
Date of birth: |_|_| |_|_| |_|_|_|_| Gender: ☐ F ☐ M

SAMPLE TYPE

☐ Refrigerated serum ☐ Frozen serum, if > 5 days

CLINICAL DETAILS

☐ YES ☐ Asymptomatic patient
☐ Fever ☐ Respiratory signs ☐ Digestive signs ☐ Acute respiratory distress syndrome
☐ Influenza like illness ☐ Kidney failure ☐ Conjunctivitis ☐ Sudden loss of smell ☐ Skin rash

CLINICAL INFORMATION

Date of sampling: |_|_| |_|_| |_|_|_|_|
Interval between clinical signs and sampling date : ..... days
Has an RT-PCR been performed ? *(nasopharyngeal sample)* ☐ YES ☐ NO
If yes, date performed: |_|_| |_|_| |_|_|_|_| **Result:** ☐ Positive ☐ Negative
Presence of scan indicative of Covid 19 ☐ YES ☐ NO

Seasonal flu vaccination ☐ YES ☐ NO
Auto-immune illness ☐ YES ☐ NO
Immunosuppressant treatment ☐ YES ☐ NO
Chemotherapy ☐ YES ☐ NO

REQUESTED TEST

☐ Pan Ig (IgA + IgG + IgM) testing ☐ IgM + IgG testing ☐ IgM testing ☐ IgG testing

R57-INTGB - May 2020