GENDIA
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SAMPLE SUBMISSION FORM

TO BE FILLED OUT BY REQUESTING PHYSICIAN/LAB

PATIENT IDENTIFICATION

Last Name:			
First Name:			
Gender:	Male ☐	Female ☐	
Date of birth:	Day	Month	Year
Ethnic origin:			
Country:			

SAMPLE INFORMATION

Type:	DNA ☐	Whole Blood ☐	Tissue ☐
Sample Number/Code:			
Date of Collection:	Day	Month	Year
Date Sent:	Day	Month	Year

TEST REQUIRED

Test Number *(check website if not sure)*	

MEDICATION

RELEVANT CLINICAL INFORMATION

REQUESTING PHYSICIAN / LAB

Last Name:	
First Name:	
Lab/Hospital Name:	
Adress:	
Country:	
Phone:	
Fax:	
E-mail:	

METHOD OF PAYMENT

I agree with the GENDIA's general Terms and Conditions and confirm to pay promptly the GENDIA invoice, which will be issued after testing is completed.

Signature:			
Date:	Day	Month	Year
Settlement:	Visa ☐	MasterCard ☐	Bank Transfer ☐

INVOICING INFORMATION

(Only fill out when different from "Requesting Physician / Lab")

Name:	
Address:	
VAT number: *(if applicable)*	
Phone:	
E-mail:	

CREDIT CARD INFORMATION

Name on Credit Card:	
Credit Card Number:	
Expiration Date:	