BIOARRAY
Diagnóstico Genético

Bioarray, S.L.
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info@bioarray.es - www.bioarray.es

Test Requisition Form for Sample Shipment

PLEASE REQUEST SAMPLE COLLECTION AT info@bioarray.es

Sender details

Medical Center / Health Facility | Service/Department | Date

First Name | Family Name | E-mail

Address | City

Province/State | Postal Code | Country | Phone

Patient details

First Name | Family Name | Gender | Date

Birthdate | Medical Record no. | E-mail

Province/State | Postal Code | Phone

Sample information

Sample type | Extraction method | Extraction date

Clinical Data *(enclosing of reports is recommended)*

Indication

Summary of relevant medical history

Requested Test

- ☐ CytoArray: aCGH focused on Clinical Genetics (498 regions, 60K).
- ☐ CytoArray Plus: aCGH focused on Clinical Genetics (610 regions, 180K).
- ☐ CytoArray UPD: detection of CNVs and Uniparental disomies (UPD) (498 regions, 180K).
- ☐ CytoArray Prenatal: aCGH focused on prenatal diagnosis.
- ☐ aCGH, higher resolutions: 400K, 1M.
- ☐ Single Gene or Gene Panel Sequencing. Please indicate pathology: _____
- ☐ Whole Exome Sequencing

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Billing Details

Medical Center / Health Facility | Tax number

First Name | Family Name | E-mail

Address | City

Province/State | Postal Code | Country | Phone

Authorized Person

Signature and Stamp

Sample Shipment

1. Please enclose this and the informed consent form, with the proof of payment and sample.
2. Sample should be extracted DNA in the minimum amount of 1 µg.
3. Introduce DNA tube and documents in a padded envelope for protected shipment.