



MOLECULAR GENETICS LABORATORY SERVICE REQUEST

FOR AJC	
Patient Code:	
Lab Order No.:	

		<u> </u>
Patient information		
Name:		☐ Male ☐ Female
Date of Birth: / /	CPR No.:	Nationality:
Clinical Indications / Family History (a	attach pedigree, if available):	
Referring Institution Details		
Referring Clinic/hospital:	eferring Clinic/hospital:	
Ordering Physician:		
Physician Phone:		
Email:		Date:
Type of Specimen		Succ.
☐ Peripheral blood	Other (pl	ease specify):
Collection date: / /	Time of coll	ection:
Test Ordered (please tick cod	de)	
(CVD)Assay: three different assays of detect genetic variants that are asso Cardiovascular Disease: DSMG001*	ociated with 0210A rombin C677T	
* Molecular genetics tests have to b	e conducted with informed c	consent of the patient / guardian.
Informed Consent		
	s, risks, and limitations of this my physician.	me / my child. My signature below constitutes testing have been explained to my satisfaction by
Patient/Guardian Signature		Date:





Specimen Requirements

T. was of Amalusia	Total Carations		n Volume	Transport	
Type of Analysis	Type of Specimen	Minimum	Ideal	Temperature	
CVD Assay	Peripheral blood (EDTA tube)	5 ml	10 mL	+2°C to + 8°C	

Note:

- Assure sample sterility.
- Close tubes properly.
- Label all samples.
- Send the sample on the day of collection if possible or store it at 4°C for up to 72 hours as maximum. "Older Samples May Be Rejected".
- Close shipping box tightly and enclose requisition form.



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