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Clinical Information Form
Infectiology

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Tel.: **+33 (0)4 72 80 23 85** • Fax: **+33 (0)4 72 80 73 56** • E-mail: **international@biomnis.com**

PRESCRIBING CLINICIAN OR REFERRING LABORATORY

PRESCRIBING CLINICIAN

Name: .....
Hospital/ward: .....
Tel.: ☐☐ ☐☐ ☐☐ ☐☐ ☐☐
Fax: ☐☐ ☐☐ ☐☐ ☐☐ ☐☐
Email address: .....

REFERRING LABORATORY

Name : .....
☐ Hospital ☐ Private Laboratory
Address/Country: .....
.....
Tel.: ☐☐ ☐☐ ☐☐ ☐☐ ☐☐
Fax: ☐☐ ☐☐ ☐☐ ☐☐ ☐☐
Email address: .....

PATIENT DETAILS*

First name(s): ..... Surname: .....
Maiden name: .....
Date of birth: ☐☐ ☐☐ ☐☐☐☐ Gender : ☐ M ☐ F
Address/Country: .....

**This information is compulsory to proceed with testing.*

SAMPLE

Sample type: .....
.....

Sample date: ☐☐ ☐☐ ☐☐☐☐

CLINICAL SYMPTOMS

Clinical onset date: ☐☐ ☐☐ ☐☐☐☐

Nature of clinical signs

☐ Digestive ☐ Renal ☐ Ocular
☐ Respiratory ☐ Urogenital ☐ Lymph node
☐ Cardiac ☐ Neurological ☐ Muscular
☐ Cutaneous ☐ Articular ☐ Others: .....

Evolution: .....

CLINICAL DETAILS

Time between the clinical onset and the sample date: ☐☐ days
History: .....
Immunodepression: ☐ YES ☐ NO Pregnancy: ☐ YES ☐ NO
Recent trip (specify the country): ..... D D M M Y Y
Contact with an animal (specify details): ..... D D M M Y Y
Arthropod sting or bite (specify): ..... D D M M Y Y
Contact with still water (specify): ..... D D M M Y Y
Others: .....
Vaccination: .....

THERAPEUTIC

Date of treatment: .....
Nature: .....

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Formular date clinice
Boli infectioase

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MEDIC PRESCRIPTOR SAU LABORATOR SUBCONTRACTANT

MEDIC PRESCRIPTOR

Nume: .....
Unitate medicala: .....
Tel.: ☐☐☐☐☐
Fax: ☐☐☐☐☐
Email: .....

LABORATOR SUBCONTRACTANT

Denumire: .....
☐Spital ☐Laborator privat
Adresa/Tara: .....
.....
Tel.: ☐☐☐☐☐
Fax: ☐☐☐☐☐
Email: .....

INFORMATII DESPRE PACIENT*

Prenume: ..... Nume: .....
Nume de fata: .....
Data nasterii: ☐☐ ☐☐ ☐☐☐☐ Sex : ☐ M ☐ F
Adresa/Tara: .....

**Informatii obligatorii pentru efectuarea testului.*

PROBA

Tip proba: .....
.....

Data recoltarii: ☐☐ ☐☐ ☐☐☐☐

SIMPTOME CLINICE:

Debutul simptomelor: ☐☐ ☐☐ ☐☐☐☐

Natura simptomelor

☐ Digestive	☐Renale	☐Oculare
☐Respiratorii	☐Urogenitale	☐Ganglioni limfatici
☐Cardiace	☐Neurologice	☐Musculare
☐Cutanoase	☐Articulare	☐Altele: .....

Evolutie: .....

DETALII CLINICE:

Nr. de zile trecut dintre simtome si data recoltarii: ☐☐ zile
Istoric: .....
Imunocompromis: ☐ DA ☐ NU Sarcina: ☐ DA ☐ NU
Calatorii recente (specificati tara): ..... D D M M Y Y
Contact cu un animal (specificati): ..... D D M M Y Y
Înțepătură sau mușcătură de artropod (specificați): ..... D D M M Y Y
Contact cu apă stătătoare (specificați) ..... D D M M Y Y
Altele: .....
Vaccinări: .....

TERAPIE

Data administrării tratamentului: .....
Natura tratamentului: .....