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Laboratorio di diagnostica molecolare

Request form for genetic testing outside the medical domain

(Insert this form filled and signed in the returning envelope)

Patient's data			
Name:		First name:	
Date of birth:		Gender:	M ◯ F ◯
Address:			
Email:			
Date of sample collection:		**Lab Number:** (leave empty)	
Report's language:	Italian ◯	French ◯	English ◯

Requested test (cross below the blue arrow)			
	↓		
Biological age	☐		
Lactose intolerance	☐		
Celiac disease exclusion	☐		

Patient's signature
Date and place:_____ Patient's signature:_____
The patient authorizes LDM SA to execute the analysis (please fill the included informed consent and insert it in the returning envelope).