

TEST REQUEST FORM

Patient identification	Name (Last, First):	
	Date of birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Identification number:	
	Address:	

Patient clinical information	Disease:
	Antiviral treatment received:
	Additional information:

Specimen information	Identification:
	Date collected:
	Type:
	Additional information:

Pattern of Antiviral Resistance required for:	<input type="checkbox"/> Human cytomegalovirus
	<input type="checkbox"/> Herpes simplex virus
	<input type="checkbox"/> Varicella-zoster virus

Requesting doctor(s) / Laboratory	Name (Last, First):	
	Hospital:	
	Department:	
	Address:	
	e-mail:	
	Tel. / Fax:	
	Date:	Signature:

Please use only one form for each requested test.