

Patient

Surname:			
First name:			
Date of birth:			
Street / No.			
Postcode:		City:	
Phone:			
E-Mail:			

Prescriber / Clinic

Surname:			
First name:			
Institution:			
Street / No.			
Postcode:		City:	
Phone:			
E-Mail:			

Delivery of report

Email the report to: _____ (HIN-encrypted e-mail addresses only)*

*A copy of the report must always be sent to the Unilabs Genetics Laboratory (genetics.ch@unilabs.com).

Invoicing

Invoice to Prescriber Patient (Health insurance: _____)

Clinical information (mandatory fill in)

Has the patient's father or brothers/sons been diagnosed with prostate cancer? Yes No Unknown

Is the patient taking or has the patient taken regularly any of the following medicines in the last three months: Avodart, Dutasteride, Proscar or Finasteride? Yes No Unknown

Has the patient already had a prostate biopsy? Yes No Unknown

Cost coverage

I was informed that the test is new in Switzerland. Typically, health insurance covers the costs of the test. However, it is possible that my health insurance company refuses to cover the costs within the framework of basic insurance and/or any supplementary insurance.

I hereby confirm that I am prepared to bear the laboratory costs for the Stockholm3 test in the amount of CHF 502.- if my health insurance does not cover the costs.

Place / Date

Patient signature

Sample

In the prepaid envelope, send two (2) 4 mL EDTA tubes filled with the patient's blood to:

Institut für histologische und zytologische Diagnostik AG
Stockholm3
Dr. med. Milo Horcic
Talstrasse 2
8702 Zollikon



2 x 4 ml EDTA
(Item no. in the
Unilabs webshop:
454209)

Doctor/Clinic stamp

Please do not send samples in before a weekend or before a public holiday!

If you are unsure or have any questions, please contact +41 (0) 21 321 40 51.

Date of sample collection: _____ Time of sample collection: _____