INFAI BRUKER

Metabo Test *INFAI*®

NMR Patient Documentation Form

Please provide the following information clearly legible.

Barcode

Physician:

Name : ______________________________

Hospital : ______________________________

Street Address : ______________________________

Zip Code / City : ______________________________

E-mail : ______________________________

Telefone : ____________________ Fax: ____________________

Patient:

Name : ____________________ Prename: ____________________

Sex : ☐ M ☐ F ☐ unknown Week of gestation: ____________________

Date of Birth : _______ - _______ - _________ Birth Weight: ____________________ g

Day Month Year

Sample Information: Date of Sample: _______ - _______ - _________

Day Month Year

Declaration Of Consent: I agree with a possible use of anonymous access to sample data for scientific questions or for the purpose of general quality assurance. ☐ yes ☐ no

Date: _______ - _______ - _________ Signature of Guardian: ____________________

Day Month Year

Clinical Findings

____

____

Medication

____

____

Body Fluids:

- Urine: 2 - 3 mL
- Read and follow the Urine Collection Instructions
- Please fill out the Sample Tracking Form on the back

MTI-PD-EN-160614

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