Test Request Form

Send sample to:

Praxis Prof. Dr. med. M. Kramer
Facharzt für Laboratoriumsmedizin
c/o MVZ Dermatohistopathologie HD
Im Neuenheimer Feld 582, 69120 Heidelberg, Germany

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Family Name:	First Name:	
Address:		
Zip Code:	City:	Country:
Phone:	E-mail:	
Date of birth:	Sex: Male/Female	
Date and hour blood drawn:		

☐ Nagalase Test (Serum) *€ 67,04*

(min. 1 ml of serum in unbreakable protection container for medical specimen)

The cost for the requested analyses will be invoiced directly to me by laboratory Prof. Dr. Kramer, at the above mentioned rate.

Signature: _____ Date: _____

A signed copy of this form must be sent together with your samples.