

Family name:	First name:	
Address:		
Zip Code:	City:	Country:
Phone:		
Date of birth:	Sex: Male / Female	
Date and hour sample taken:		
Name of requesting physician:	Your patient ref.:	

Intestinal Flora, Stool Analysis

<input type="checkbox"/> FMA1	Faecal microbial analysis 1 Aerobe and anaerobe bacteria, yeast, fungi	248 €	Sample required: Stool. Request test kit containing specimen container and shipment instructions. Ship within 48 hours at 4°C
<input type="checkbox"/> FMA2	Faecal microbial analysis 2 Follow-up. Aerobe bacteria only	149 €	
<input type="checkbox"/> DIGS	Stool analysis, digestive function Starch, muscle fibers, fat in stool	20 €	Sample required: Stool. Ship within 48 hours at 4°C

Antibiograms

<input type="checkbox"/> STAP	Antibiogram Staphylococci Penicillin, Gentamycin, Erythromycin, Clindamycin, Tetracycline, Vancomycin, Teicoplanin, Rifampicin, Fusidic acid, Dalfopristin/Quinupristin	30 €	Sample required: Stool. Antibiogram is performed on bacteria isolated from FMA1 or FMA2. FMA1 or FMA2 must therefore be requested. Request test kit containing specimen container and shipment instructions. Ship within 48 hours at 4°C
<input type="checkbox"/> STRE	Antibiogram Streptococci Penicillin, Amoxicillin, Cefotaxime, Erythromycin, Dalfopristin/Quinupristin, Clindamycin, Tetracyclines (Oxytetracycline), Levofloxacin, Chloramphenicol, Vancomycin, Moxifloxacin	30 €	
<input type="checkbox"/> ECOC	Antibiogram Enterococci Penicillin, Ampicillin, Erythromycin, Tetracycline, Rifampicin, Ciprofloxacin, Levofloxacin, Vancomycin, Teicoplanin, Dalfopristin/Quinupristin	30 €	
<input type="checkbox"/> EBAC	Antibiogram Enterobacteriaceae Amikacin, Amoxicillin, Amoxicillin + Clavulanate, Cefotaxime, Cefoxitin, Ceftazidim, Ciprofloxacin, Imepenem, Meropenem, Tobramycin	30 €	

If you wish to test another antibiotic, please write a note below:

I am aware that the laboratory has no RIZIV number. These tests are «research only»; interpretation must be done by a health care professional. The cost for the requested analyses will be invoiced directly to me by R.E.D Laboratories, at the above mentioned rate. I hereby authorise R.E.D Laboratories to possibly use my sample for research purposes.

Signature:

Date:

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

We do accept :  