



# REQUEST FORM FOR MICROBIOLOGICAL EXAMINATION (SELF-PAYER)



GHC GENETICS

## PATIENT

Name and surname

Male

Female

Address

Birth no./Insurance no.

Phone number

E-mail

Diagnosis

Week of pregnancy

Patient label/Doctor's stamp

Date of first symptoms

Clinical comment

## SAMPLE TYPE

Blood (B)

Swab (S) type:

Urethral

Cervical

Rectal

Throat

Other material (O) –  
In agreement with the laboratory

## PERFORMED EXAMINATIONS

Test name	Performed examinations	Sample	Price
<input type="checkbox"/> STD VAGINAL	<i>Gardnerella vaginalis</i> , <i>Candida albicans</i>	S	800 Kč
<input type="checkbox"/> STD BASIC	HIV, <i>Treponema pallidum</i> (Syphilis), Hepatitis C	B	1 250 Kč
<input type="checkbox"/> STD STANDARD	<i>Chlamydia trachomatis</i> , <i>Neisseria gonorrhoeae</i> , <i>Mycoplasma genitalium</i> , <i>Trichomonas vaginalis</i> , <i>Mycoplasma hominis</i> , <i>Ureaplasma urealyticum</i> , <i>Ureaplasma parvum</i>	S	1 700 Kč
<input type="checkbox"/> STD COMPLEX	HSV (herpes simplex virus), <i>Chlamydia trachomatis</i> , <i>Neisseria gonorrhoeae</i> , <i>Mycoplasma genitalium</i> , <i>Trichomonas vaginalis</i> , <i>Mycoplasma hominis</i> , <i>Ureaplasma urealyticum</i> , <i>Ureaplasma parvum</i> , HPV (human papillomavirus)	S	2 250 Kč
<input type="checkbox"/> STD PREMIUM	HIV, <i>Treponema pallidum</i> (Syphilis), Hepatitis C, HPV (Human papillomavirus), HSV (herpes simplex virus), <i>Chlamydia trachomatis</i> , <i>Neisseria gonorrhoeae</i> , <i>Mycoplasma genitalium</i> , <i>Trichomonas vaginalis</i> , <i>Mycoplasma hominis</i> , <i>Ureaplasma urealyticum</i> , <i>Ureaplasma parvum</i>	B + S	2 950 Kč
<input type="checkbox"/> STD PREMIUM 2v1	STD PREMIUM+throat swab, rectal and urethral/cervical smear (two arbitrary smears)	B + S	4 450 Kč
<input type="checkbox"/> STD PREMIUM 3v1	STD PREMIUM + throat swab, rectal and urethral/cervical smear	B + S	5 950 Kč
<input type="checkbox"/> TORCH	CMV, EBV, HSV1/2, Rubella, <i>Toxoplasma gondii</i>	B	4 000 Kč
<input type="checkbox"/> Hepatitis A	Anti HAV total	B	400 Kč
<input type="checkbox"/> Hepatitis B	HbsAg, anti HBs, anti HBc	B	1 025 Kč
<input type="checkbox"/> Hepatitis C	anti HCV	B	360 Kč
<input type="checkbox"/> Hepatitis A+B antibodies	Anti HBs, anti HAV total	B	750 Kč
<input type="checkbox"/> HSV	Herpes Simplex Virus 1 and Herpes Simplex Virus 2	S	1 700 Kč
<input type="checkbox"/> HPV	24 high-risk types HPV	S	1 700 Kč
<input type="checkbox"/> Syphilis	Anti + RPR	B	435 Kč
<input type="checkbox"/> HIV	Anti + P24	B	350 Kč
<input type="checkbox"/> Chlamydia trachomatis Neisseria gonorrhoeae	PCR	S	1 500 Kč
<input type="checkbox"/> Chlamydia trachomatis protilátky	IgA - acute condition, IgG - after infection	B	980 Kč
<input type="checkbox"/> Toxoplasmosis	Toxo IgG, Toxo IgM	B	2 000 Kč
<input type="checkbox"/> Antibiotic resistance	( <i>Ureoplasma</i> spp., <i>Mycoplasma hominis</i> )	B	600 Kč
<input type="checkbox"/> International certificate	Issuance of the INTERNATIONAL CERTIFICATE FOR THE PRESENCE OF HIV ANTIBODIES		190 Kč
<input type="checkbox"/> Express result within 24 hours	Applies to all of the above examinations		1500 Kč

Date and time of collection

Date and time of receipt

Request form number  
(completed by the laboratory)



**3-5 ml of clotting  
blood is required  
for serological  
testing**

### INFORMING THE CLIENT ABOUT THE PRICE OF THE MEDICAL PROCEDURE

The self-payer was advised by the health care professional of the cost of the medical procedure and voluntarily chose to have the procedure performed. The client declares that he/she has been advised that in some cases the procedure may also be covered by public health insurance and the client requests the provision of the procedure for direct reimbursement. The client agrees to pay the requested amount for the medical procedure within 14 days of signing the request form. The examination will be performed after receipt of payment to the bank account, the tax document will be sent to the client's address, by e-mail, or collect it in person.

### PAYMENT

A) bank transfer to the account number 1990237/0100 (VS: request form number),  
IBAN: CZ53 0100 0000 0000 0199 0237, SWIFT: KOMBCZPP

B) In cash at the reception (in person at the registered office)

GHC GENETICS, s.r.o.

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info@ghcgenetics.cz. Medical laboratory No.8124 accredited by the CAI in accordance with ČNS EN ISO 15189:2013.

Scope of accreditation at [www.ghcgenetics.cz](http://www.ghcgenetics.cz)



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