

HARMONY CONSUMABLES RE-ORDER FORM

Doctor/Practice:

DATE OF ORDER

Address:

Requested by:

Tel:

IF URGENT BY

For initial orders clinics are required to contact the laboratory.

I would like more information about providing Harmony testing in my practice

CONSUMABLES ORDER

No. Required

- | | | |
|-----------------------------------------------------------------------------------------------------|---|---|
| <input type="checkbox"/> Harmony packs with track 24 postal envelope | [|] |
| <input type="checkbox"/> Harmony packs without postal envelope (for courier collection only) | [|] |
| <input type="checkbox"/> Patient information leaflet | [|] |

SUBMIT FORM

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