**REQUEST OF SERVICES TO THE CYTOMICS UNIT**

*For the Hospital U. i P. La Fe*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | | | | **Nº APPLICATION:** | | | | |  | | | |
| **APPLICANT DETAILS** | | | | | | | | | | | | | | | | | | | | | |
| Date of Request: | | | | | | |  | | | | | | | | | | | | | | |
| Applicant name: | | | | | | |  | | | | | | | | | | | | | | |
| Unit’s responsible: | | | | | | |  | | | | | | | | | | | | | | |
| Unit/Service: | | | | | | |  | | | | | | | | | | | | | | |
| Phone: |  | | | | | | Mobile: | | |  | | | | | | | E-mail: | |  | | |
| **BILLING DATA** | | | | | | | | | | | | | | | | | | | | | |
| CIF: | | S-4611001-A | | | | | | Fiscal Name: | | | | | | Hospital Universitario y Politécnico La Fe | | | | | | | |
| Address: | | Avda. Fernando Abril Martorell, 106 | | | | | | | | | | | | | | | | | | | |
| Province: | | Valencia | | | | | City: Valencia | | | | | | | | | | | Postal Code: 46026 | | | |
| Contact of the Administration Dept.: | | | | | | | | | | | |  | | | | | | | | | |
| Phone: | | |  | | | | | | | | | Email: | | | |  | | | | | |
| **REQUESTED SERVICE** | | | | | | | | | | | | | | | | | | | | | |
| **CODE** | | | | **DESCRIPTION** | | | | | | | | | | | | | | | | | **PRICE** |
|  | | | |  | | | | | | | | | | | | | | | | | **€** |
|  | | | |  | | | | | | | | | | | | | | | | | **€** |
| **TOTAL BUDGET** *(IVA not included)* | | | | | | | | | | | | | | | | | | | | | **€** |
| I request the service indicated above, in the case of modification of the application, a complementary request will be made, if necessary | | | | | | | | | | | | | | | | | | | | | |
| **PATIENT'S DATA** *(this form should not include patient data other than those listed below)* | | | | | | | | | | | | | | | | | | | | | |
| Acronym of the patient: | | | | |  | | | | SIP: | |  | | | | | | | | | | |
| **Signature of the applicant** | | | | | | **Signature and seal of Director of the Area or Chief of the Service** | | | | | | | | | **Vº Bº Economic Direction Dept. of Health Valencia La Fe** | | | | | **Acceptance by Cytometry Unit** | |
| Name:  Date: | | | | | | Name:  Date: | | | | | | | | | Name:  Date: | | | | | Name:  Date: | |