



Client information	
Doctors name/Institution	
Street	
Postcode, Town	
Country	
Basic patient information	
Name	<input type="radio"/> female <input type="radio"/> male
First name	Date of birth

Laboratory Medicine Dortmund – Genetics

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Fax: +49 231 57 98 34

genetik@labmed.de
www.labmed-international.de

Queries to sender
E-Mail
Phone

Specimen notes
Date/Time
<input type="radio"/> EDTA blood
<input type="radio"/> Lithium heparin
<input type="radio"/> DNA
<input type="radio"/> Swap
<input type="radio"/> Other specimen / comments ...

For laboratory use only!
Order number

Clinical Lab Request

Date: 16.06.2021

Requested genetic analysis

Spherocytosis / hereditary spherocytosis

Contact: Dipl. Biol. Thomas Zielsdorf, Tel: +49 231 9572-6600

A detailed list of analyzed genes can be found on www.labmed.de; additional genes on request.

Remarks / additional analyses:

Patient and Family information

Clinical findings:

Family history:

- Has the analysis already been performed in an affected relative? Yes No
- If **YES**, please provide a copy of the result (this may increase the validity of the report and potentially reduces analytical costs)
- If **NO**, please state: affected family member not analyzed deceased report not available
- Is the patient (or his partner) currently pregnant? Yes, week of gestation: No
- Parents' ethnicity consanguineous partnership? Yes No

Information: This requisition form is a binding order for tests that are subject to a charge to be paid by the client / signatory of this requisition form. The costs and terms of payment are specified in our quotation (if requested in advance).

Place, date

Block letters and signature of **patient or patient's legal guardian**

Block letters (or stamp) and signature of **referring physician**

Declaration of the patient's informed consent is mandatory! Please see next page.

Declaration of informed consent

With my signature, I declare that I have been provided comprehensive information about

- the genetic background related to the disease in question, as well as the consequences and limitations of molecular genetic test
 - recording, storage and handling of my personal data
 - (if not yet happened) the possibility of genetic counselling by physician specialized in clinical genetics
 - my right of an appropriate time for consideration and to withdraw my consent for genetic analyses
 - my right not to receive the results of the requested genetic analyses
 - the disposal of the results of the requested analyses after 10 years
 - the disposal of my specimen after completion of the analyses
 - the possibility, that the analyses may yield incidental findings that are not directly related to the above mentioned clinical question.
 - I want to receive such additional results (no tic will be interpreted as „only, if...“):
 - No Yes Only, if these implicate therapeutical or preventive consequences for me or my relatives
- (This does not result in any claim for completeness or future updates of additional results)

I declare my consent (please cross out if not applicable):

- for the required drawing of a (blood) sample,
- to the above mentioned molecular genetic analyses
- , that the results may be communicated to my attending physicians
- , that analyses may be forwarded to a specialized cooperating laboratory
- , that in case of high throughput analyses genetic data may be obtained (but not necessarily analyzed) which are not related to the above mentioned clinical question
- , that the sample and data may be stored and used in a pseudonymized form for quality control and scientific purposes
- , that in case of gene panel analyses the composition of the list of analyzed gene may be modified according to clinical findings or the current state of knowledge and may also comprise genes for important differential diagnoses

.....
Place, date

.....
Block letters and signature of **patient or patient's legal guardian**

.....
Block letters (or stamp) and signature of **referring physician**

If the patient did not sign this form:

I, the referring physician, hereby confirm that the patient has received genetic counseling and has given written consent to the above mentioned genetic analyses.

.....
Place, date

.....
Block letters (or stamp) and signature of **referring physician**