Überörtliche Berufsausübungsgemeinschaft
MVZ · Dr. Eberhard & Partner Dortmund

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Client information

Doctors name/Institution

Street

Postcode, Town

Country

Basic patient information

Name ○ female ○ male

First name Date of birth

Queries to sender

E-Mail

Phone

Specimen notes

Date/Time

- ○ EDTA blood
- ○ Lithium heparin
- ○ DNA
- ○ Swap
- ○ Other specimen / comments ...

For laboratory use only!

Order number

Clinical Lab Request

Date: 01.02.2023

Requested genetic analysis

ABCC2 for Dubin-Johnson syndrome

Contact: Dr. rer. nat. Thomas Haverkamp, Tel: +49 231 9572-6617

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 familiy 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**