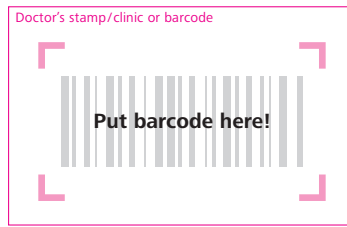


Health Insurance		
Surname, First Name		Date of birth
Health Insurance ID No.	Personal Insurance ID No.	Status
Business No.	Doctor's ID	Date



0051002701

# laborkrone

**MVZ Labor Krone GbR**

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## Consent form for requesting genetic diagnostics according to GenDG

**Submitter** Physician \_\_\_\_\_ Phone \_\_\_\_\_

**Patient information**

Gender  Female  Male  Diverse Ethnic origin \_\_\_\_\_

Type of investigation  **Affected/Diagnostic**  **Predictive/Carrier-screening**

Anamnesis/Indication \_\_\_\_\_

Genetic findings available? (Own/Family members)  Yes (Please attach a barcoded document)  No

**Cost Unit**  Statutory health insurance (Please attach a referral!)  Privately insured  Self-payer

**Desired Analysis (Please choose)**

**Coagulation** **EDTA**  Factor-V-mutation  Factor-II-prothrombin-mutation  
 MTHFR-Polymorphism  PAI 4G/5G

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**HLA** **EDTA**  HLA-B27  HLA according to request:  
 HLA-DQ2/DQ8 (Gluten intolerance) \_\_\_\_\_  
 HLA-B5701 \_\_\_\_\_ (Please fill in)

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**Children desired/ Abortions** **EDTA**  Thrombophilia/recurrent abortion  Chromosomes **LI-HEPARIN**<sup>1</sup>  
 Azoospermia (AZF/CBAVD)<sup>1</sup>  
 Prem. menopause (FMR1/FSHR/BMP15)<sup>1</sup>

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**Syndromes** **EDTA**  Array-analysis<sup>1</sup>  Single Gene/Panel<sup>1</sup>: \_\_\_\_\_  
 Fragile-X-syndrome (FMR1)<sup>1</sup>  
 Chromosomes **LI-HEPARIN**<sup>1</sup> \_\_\_\_\_ (Please enter request/genes)

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**Others** **EDTA**  Cystic fibrosis (CFTR)<sup>1</sup>  DPYD-Variants (prior to 5-FU-Therapy)  
 Beta-Thalassaemia (HBB)<sup>1</sup>  Fetal RhD<sup>1</sup>  
 Lactose intolerance  Others<sup>1</sup>: \_\_\_\_\_  
 Fructose intolerance  
 Hemochromatosis (HFE) \_\_\_\_\_ (Please enter request/genes)

<sup>1</sup> Transfer to a partner laboratory

**Consent according to the German Genetic Diagnostic Act (GenDG)**

Herewith in agreement with this consent form and completed consultation, I confirm that I had sufficient time to reconsider my desire to have the requested genetic analyses performed and the sampling material to be taken as required per the German Genetic Diagnostic Act. I was informed in detail about the purpose of this examination, the disease to be examined and its genetic basis, as well as the possibilities and limits of the diagnostics to be carried out in my specific case. I consent to the report being sent to the requesting physician and to the physicians specified by me. I agree to:

The <b>forwarding of the request contract</b> , if necessary, to a specialized cooperating laboratory	<input type="checkbox"/> No	<p><b>Information about additional findings:</b> In rare cases, medical findings, which are not related to the initial question can be received, but which have a treatment consequence for me or my family (following the recommendations of the ACMG).</p> <p>I would like to be informed about such findings (as far as no choice has been made below, „no“ is assumed).</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>This declaration of consent in accordance with GenDG is valid for me and for my child on its behalf, and may be revoked in parts or fully at any time.</p>
The <b>storing of results</b> for and exceeding the statutory period of 10 years	<input type="checkbox"/> No	
The <b>storing of material</b> for possible testing at a later stage	<input type="checkbox"/> No	
The <b>use of testing material</b> for the purpose of quality assurance and research	<input type="checkbox"/> No	
The <b>use of test results</b> for the purpose of advising and testing of family members	<input type="checkbox"/> No	

\_\_\_\_\_  
Surname and First Name of informing physician

\_\_\_\_\_  
Place, Date

\_\_\_\_\_  
Signature of physician

\_\_\_\_\_  
Signature of patient/Legal guardian