Health Insurance

Surname, First Name

Date of birth

Health Insurance ID No. | Personal Insurance ID No. | Status

Business No. | Doctor's ID | Date

Doctor's stamp/clinic or barcode

Put barcode here!

0051002701

laborkrone

MVZ Labor Krone GbR
Prof. Dr. med. B. Dufaux
Dr. med. Dr. rer. nat. D. Münstermann
Siemensstraße 40
32105 Bad Salzuflen · Germany
Phone +49(0)5222 8076-0
info@laborkrone.de
www.laborkrone.de

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**

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

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

Syndromes EDTA
- ☐ **Array-analysis[1]**
- ☐ **Fragile-X-syndrome (FMR1)[1]**
- ☐ **Chromosomes** LI-HEPARIN [1]
- ☐ **Single Gene/Panel[1]:** _____ (Please enter request/genes)

Others EDTA
- ☐ **Cystic fibrosis (CFTR)[1]**
- ☐ **Beta-Thalassaemia (HBB)[1]**
- ☐ **Lactose intolerance**
- ☐ **Fructose intolerance**
- ☐ **Hemochromatosis (HFE)**
- ☐ **DPYD-Variants (prior to 5-FU-Therapy)**
- ☐ **Fetal RhD[1]**
- ☐ **Others[1]:** _____ (Please enter request/genes)

[1] 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 **forwarding of the request contract**, if necessary, to a specialized cooperating laboratory ☐ No

The **storing of results** for and exceeding the statutory period of 10 years ☐ No

The **storing of material** for possible testing at a later stage ☐ No

The **use of testing material** for the purpose of quality assurance and research ☐ No

The **use of test results** for the purpose of advising and testing of family members ☐ No

Information about additional findings: 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).

I would like to be informed about such findings (as far as no choice has been made below, „no" is assumed).

☐ **Yes** ☐ **No**

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.

Surname and First Name of informing physician | Place, Date | Signature of physician | Signature of patient/Legal guardian