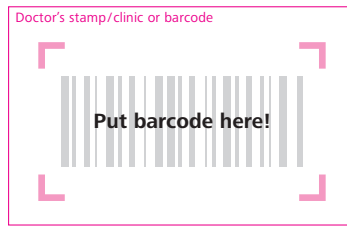


Health Insurance		
Surname, First Name		Date of birth
Health Insurance ID No.	Personal Insurance ID No.	Status
Business No.	Doctor's ID	Date



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laborkrone

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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

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

Desire for child/Abortions Chromosomes **LI-HEPARIN**¹ Azoospermia (AZF/CBAVD)¹ **EDTA**
 Thrombophilia/recurrent abortion **2x EDTA, 2x Citrat, 1x Serum**
 Premature menopause (FMR1/FSHR¹/BMP15¹) **EDTA**

Syndromes **EDTA** Array-analysis¹ Single Gene/Panel¹:
 Fragile-X-syndrome (FMR1) _____
 Chromosomes **LI-HEPARIN**¹ _____ (Please enter request/genes)

Others **EDTA** Cystic fibrosis (CFTR)¹ DPYD-Variants (prior to 5-FU-Therapy)
 Beta-Thalassaemia (HBB)¹ Fetal RhD¹
 Lactose intolerance Others¹: _____
 Fructose intolerance _____ (Please enter request/genes)
 Hemochromatosis (HFE) _____

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 [www.gesetze-im-internet.de/genDG/]. 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	<input type="checkbox"/> No
The storing of results for and exceeding the statutory period of 10 years	<input type="checkbox"/> No
The storing of material for possible testing at a later stage	<input type="checkbox"/> No
The use of testing material for the purpose of quality assurance and research	<input type="checkbox"/> No
The use of test results for the purpose of advising and testing of family members	<input type="checkbox"/> 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 informing physician* Signature of patient/Legal guardian

*In case of **predictive genetic testing**, I confirm as the attending physician that I have the necessary qualification according to GenDG.