

**Patient data** (please fill out clearly in **block letters**)

Family name

\_\_\_\_\_

First name

\_\_\_\_\_

Date of birth

\_\_\_\_/\_\_\_\_/\_\_\_\_

Day Month Year

Id. No.

\_\_\_\_\_

Age

\_\_\_\_

- male  
 female



\_\_\_\_\_

Request form

**CHROMOSOME ANALYSIS  
POSTNATAL**



Konrad-Adenauer-Str. 17  
55218 Ingelheim, Germany  
Phone +49-6132-781-240  
Fax +49-6132-781-236  
E-mail: int.support@bioscientia.com  
Website: www.bioscientia.com

**Client data**

Physician

**Sample type**

**postnatal**

- Blood / heparin tube  
 Skin biopsy  
 Slides / fixed cells

Sampling date:

\_\_\_\_/\_\_\_\_/\_\_\_\_

Time:

\_\_\_\_:\_\_\_\_

No. of tubes sent

\_\_\_\_

**Chromosome analysis required<sup>1</sup>:**

- Chromosome analysis  
 Newborn  Suspected mosaicism
- Metaphase FISH analysis (microdeletion analysis<sup>2</sup>):  
 Prader-Willi / Angelman syndrome  
 Miller-Dieker syndrome  
 DiGeorge / Velocardiofacial syndrome  
 Smith-Magenis syndrome  
 Williams-Beuren syndrome  
 Cri-du-Chat syndrome  
 Wolf-Hirschhorn syndrome  
 others (on request):  
\_\_\_\_\_  
\_\_\_\_\_

**Clinical data and indication:**

- Female  
 Male
- Multiple congenital anomalies  
 Developmental delay  
 Mental retardation  
 Dysmorphic features  
 Habitual abortion  
 Growth retardation  
 Infertility  
 IVF-ICSI  
 parental chromosome analysis following abnormal results of a prenatal/postnatal analysis:  
\_\_\_\_\_  
\_\_\_\_\_
- other clinical comments  
(please specify or attach relevant reports):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Array CGH (use request form „Array-CGH“ and submit EDTA blood)

**DNA analysis:** \_\_\_\_\_

(name of analysis/use request form „DNA analyses“ and submit EDTA blood)

<sup>1</sup> These examinations require preparation and analyses of multiple slides. If prepared material contains no mitosis, a handling fee will be charged.  
<sup>2</sup> includes chromosome analysis

**Declaration of Informed Consent**

With my signature I declare that I was briefed on

\_\_\_\_\_  
by \_\_\_\_\_  
(physician)

about the nature, importance and implications of the genetic test and that I give my consent to the following genetic analyses and to the collection of the blood and tissue samples needed for this purpose:

I consent to the storage, in accordance with legal requirements, of the recorded data in paper and/or electronic form and to their use and/or publication in

pseudoanonymized form for scientific purposes or for quality assurance.

I agree that, contrary to legal requirements, my test results will not be destroyed after 10 years (to allow my family access to them in the event of my death).

I consent to the results of the tests being made available to the following persons in addition to the doctor who submitted them:

I hereby agree to the transfer, in accordance with § 950 BGBI, of any test material remaining at the end of the analysis to the laboratory that carried out the analysis and I consent to its use for scientific purpose in pseudoanonymized form.

I consent to the communication of my data to a medical billing clearing house for invoicing purposes.

I am aware that I may withdraw this consent at any time, verbally or in writing, without giving reasons and without this having any adverse consequences for me.

-Please delete as appropriate -

Place, date:

\_\_\_\_\_  
Name of patient / legal representative:

\_\_\_\_\_  
Signature of patient / legal representative:

Please tear off this strip before sending.

Beleg Nr. 410026\_500869

Copyright bioscientia® 07.2014 · Nachdruck verboten. · ABD 1403773 · Art.Nr.