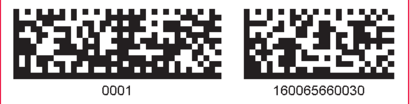

Patient data (please fill out clearly in **block letters**)

Family name

First name

Date of birth

Day Month Year

Id. No.

Age

☐ male
☐ female

CHROMOSOME ANALYSIS POSTNATAL

BIOSCIENTIA
INTERNATIONAL

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 requested:

- ☐ Chromosome analysis
  - ☐ Newborn
  - ☐ Suspected mosaicism
- ☐ Metaphase FISH analysis (microdeletion analysis):
  - ☐ 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 (please specify):
- ☐ other clinical comments (please specify or attach relevant reports):

Declaration of Informed Consent

With my signature I declare that I was briefed on

______.______.______

by ____
(physician)

about the purpose, nature, extend, validity 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 of the biospecimen and the recorded data in paper an/or electronic form and to their use and/or publication in pseudoanonymized form for scientific purposes or for quality assurance, in accordance with legal requirements.

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 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:

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These labels are for the patient´s tube(s). Those labels not needed - please tear off and discard - do not send to us.