

Application Form for DNA-Testing

Patient identification

Sample type: DNA blood buccal swab other: _____

Last Name: _____ First Name: _____ Date of Birth: _____

Gender: male female Ethnic origin: _____ Country: _____

Short clinical description (optional): _____

Requesting physician /clinic

Last Name: _____ First Name: _____

Name of the institution: _____

Adress: _____

Country: _____

e-mail: _____ Phone: _____ Fax: _____

Payment: invoice in advance CreditCard PayPal

Date: _____ Signature: _____

Requested analysis

Disease name: _____ Synonym: _____

Gene symbol: _____ OMIM: _____

Other: _____

Consent to genetic testing

Patient

Last Name: _____ First Name: _____ Date of Birth: _____

I hereby agree that genetic testing will be performed on me / my child and that the material will be stored for review of results and for any additional test that may be necessary to obtain a clear result or for research purposes.

(Place/Date)

(Signature of Patient/Parent)

(Name, Stamp of Physician)

(Signature of the Physician)