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REQUISITION FORM

Patient identification

Sample type: O DNA O blood O buccal swab O other: _____

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

Hospital/Patient ID # _____ Gender: O male O female

Ethnic origin: _____ Country of Birth: _____

Indication for test, family history: _____

Short clinical description (optional): _____

Requesting physician /clinic

Last Name:_____ First Name:_____

Name of the Institution/Clinic: _____

Adress: _____

_____

Country: _____

e-mail: _____ Phone: _____ Fax:_____

Payment: O invoice O in advance O CreditCard O PayPal

Date:_____ Physician 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)