Date (dd/mm/yyyy): ……/……/…… time of sample reception: ……	**Sample code:**
Sample accepted by: ……	……

NZOZ Genomed
ul. Ponczowa 12, 02-971 Warsaw, Poland
Tel: +48 22 644 60 19, Tel./Fax: +48 22 644 60 25
e-mail: diagnostyka@genomed.pl

ORDER FORM FOR GENETIC TESTING

GENOMED-6

PATIENT INFORMATION

First and last name (in print):

……

……

National ID No: ☐☐☐☐☐☐☐☐☐☐☐

Date of birth (dd/mm/yyyy): ……/……/……

Sex: female ☐ male ☐ unknown ☐

Ethnic origin:

☐ Polish ☐ other ……

Mailing address:

……

……

Contact phone number: ……

CODE of the relative/partner's sample or first and last name / DOB*

……

*to be filled if the person to be tested is a relative / partner of a person previously tested in NZOZ Genomed

REQUESTING UNIT INFORMATION
(INVOICE INFORMATION)

Name of the unit: ……

……

……

……

Address: ……

……

……

Telephone: ……

Fax: ……

Full name of the referring / requesting physician:

……

……

Contact phone number: ……

E-mail:……

ADDRESS TO WHICH THE RESULT SHOULD BE SENT (if other than that of requesting unit) OR THE PERSONAL DATA OF THE PERSON AUTHORISED TO COLLECT IT

……

……

……

TEST INFORMATION:

NZOZ Genomed procedure code:

……

Alternatively:

Name of the disease:

……

Gen(es): ……

Scope of the testing:

☐ selected variants (please specify)

……

☐ selected exons (please specify)

……

☐ whole coding region of the tested gen(es)

SAMPLE INFORMATION

Type of biological material:

☐ peripheral blood
☐ blood spot
☐ saliva
☐ DNA
☐ trophoblast
☐ amniotic fluid
☐ other ……

Date of sample collection:

(dd/mm/yyyy): ……/……/…… time ……

Signature and stamp of the person who collected the sample material:

……

The purpose of the test *(mark the appropriate one)*:

☐ **Postnatal diagnostics**

☐ Verification of a clinical diagnosis:

Indications for carrying out the test:

☐ Clinical symptoms of the disease *(please specify)*:

……

……

……

☐ Male infertility

clinical examination confirmed: ☐ non-obsctructive azoospermia ☐ obsctructive azoospermia (CBAVD) ☐ oligospermia

☐ Recurrent miscarriages of the patient / the partner of the patient

number of miscarriages: …….

☐ Determination of carrier status in non-symptomatic individual:

Indications for testing:

☐ Positive case history in the family (please state the kinship with the affected person):

……

……

……

(in case of malignant diseases please state the type of the cancer diagnosed and age of onset in all affected family members).

☐ Determination of predisposition to genetic disease

☐ Assessment of genetic reproductive risk

☐ **Prenatal diagnosis** week of pregnancy: ……

(please attach the screening test results or other examinations concerning the fetus)

☐ ***Post mortem* diagnostics**

☐ Defining the gender of an aborted fetus for legal purposes

☐ Molecular karyotype (aCGH)

☐ Other: ……..

☐ **Bio-banking of genetic material**

Has a genetic test ever been done before? ☐ yes ☐ no

If YES, what was the scope and the result of testing (please attach):

.....

Have genetically determined diseases ever occurred in the family? ☐ yes ☐ no

If YES, please specify the disease and the degree of kinship with the proband / the affected person and results of the genetic testing, if performed:

……

.....

Information about bone marrow transplants / blood transfusions:

Has the patient ever had a bone marrow transplant? ☐ yes ☐ no

* a bone marrow transplant is a contraindication to genetic testing from blood and saliva

Has the patient undergone a blood transfusion within the last 3 months? ☐ yes ☐ no

* genetic testing should not be performed until 3 months after a transfusion, otherwise the obtained diagnostic result may be incorrect

……. Date	…… Signature and stamp of the referring physician