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Meds&Me

TEST REQUIRED: **MEDS&ME Pharmacogenomics Test (Code: PGX)** ☑

PATIENT DETAILS

Forename _____ **Surname** _____

Address _____

_____

Patient Phone number _____

Date of Birth: ____ / ____ / _____ (DD / MM / YYYY) **Gender at Birth:** **Male** ☐ **Female** ☐

Date of Sample Collection: ____ / ____ / _____ (DD / MM / YYYY) **Type of Sample:** **EDTA** **Blood**

Clinical Details: _____

_____

Please note: Patient must NOT have received a blood transfusion in the last 4 weeks or had a kidney, liver or bone marrow (organ) transplant.

REQUESTING HOSPITAL / CLINIC

Hospital / Clinic Name: _____

Location Code: _____ **Doctor Code**: _____ **Doctor's Name**: _____

Address: _____

_____

Phone: _____ **Email**: _____

GENETIC TESTS REQUIRE SIGNED PATIENT CONSENT

Turn Over page to sign the Informed Consent Form

For Laboratory Use Only
Affix Barcode here

Eurofins Biomnis Ireland Limited
t/a Eurofins Biomnis
Your Partner in Pathology

Company registration number: 176482

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SIGNED PATIENT CONSENT

I understand that the pharmacogenomics test (PGx test) analyses specific genetic variants that may affect how I respond to certain medicines. I understand that this test is not diagnostic and is intended to support prescribing decisions. I understand that all clinical decisions remain the responsibility of my treating clinician. The pharmacogenomics report (PGx report) does not replace clinical assessment, medical diagnosis or professional judgement.

I authorise Eurofins Biomnis Ireland, on behalf of my professional healthcare medical provider, to handle the logistics of transporting my sample and carry out the genetic analysis. I understand that the laboratory uses PGXperts software as part of the technical analysis process.

I confirm that I have been given clear information by my professional healthcare medical provider, about the nature, purpose, scope and possible implications of the genetic test. I have had the opportunity to ask questions, all of which have been answered to my satisfaction, and I have been given sufficient time to consider whether to proceed with the test.

By signing below, I give my explicit consent to:

- the collection of the required biological sample (blood or saliva)
- the performance of pharmacogenomics testing
- the collection, storage, and processing of my personal and genetic data in electronic and paper form in accordance with the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 (Ireland)

I confirm that:

- I have not had a blood transfusion in the last 4 weeks or had a kidney, liver or bone marrow (organ) transplant.

I understand that:

- I may withdraw my consent, in whole or in part, at any time without giving reasons and without any adverse consequences for my care
- Whilst I have the right to receive my test results, I also have the right not to receive my test results (right not to know)
- I may request that testing be stopped at any time prior to the communication of results and that the sample material and any results obtained up to that point be destroyed, unless retention is required by law.

I expressly consent to the processing of my personal and genetic data in accordance with General Data Protection Regulation (GDPR) and the Data Protection Act 2018 and have read and understood points above. My signature confirms that I am placing this test order voluntarily.

Doctor Signature

Date ___ / ___ / ____
DD MM YYYY

Patient / Legal Guardian Signature (if applicable i.e. for under 18 years of age)

Date ___ / ___ / ____
DD MM YYYY

Legal Guardian Name (BLOCK CAPITOLS) (if applicable i.e. for under 18 years of age)

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