Eurofins Biomnis Genetic Test Request, Information & Consent Form

PATIENT DETAILS

Surname: _____

Forename: _____

Date of Birth: _____/_____/_____

Sex: Male ☐ Female ☐

Hospital/Clinic No.: _____

Laboratory No.: _____

Ward: _____

Physician: _____

REQUESTING HOSPITAL/ CLINIC DETAILS

Hospital / Clinic Name:

_____

Department:

_____

Address: _____

_____

_____

Phone: _____Fax: _____

PLEASE REMEMBER ALWAYS TO COMPLETE THE INFORMED CONSENT SECTION

TESTS REQUIRED

MOLECULAR GENETICS

TEST NAME	CODE	SELECT
Array CGH Analysis	CGH	☐
Chromosome Y Microdeletions	YQ	☐
Cystic Fibrosis Screen (most common mutations)	CF36	☐
Factor V Leiden PCR	FAC5	☐
Fragile X Chromosome	FRAGX	☐
Haemochromatosis	HFE	☐

TEST NAME	CODE	SELECT
Huntingtons Disease	HUNT	☐
MTHFR Mutation C677T	MTHFR	☐
Muscular Dystrophy (Duchenne's)	DUCH	☐
Prothrombin (Factor II) Mutation	PTMUT	☐
Rett's Syndrome	RETT	☐
PAI-1 Mutation	PAI1M	☐

Other Please Specify: _____

CYTOGENETICS

TEST NAME	CODE	SELECT
Chromosome Analysis / Karyotyping - Whole Blood	KARY	☐
Chromosome Analysis – Products of Conception	KARPP	☐

TEST NAME	CODE	SELECT
Prader Willi Syndrome (15q11- 13Methylation)	PRAD2	☐
William's Syndrome	WILL	☐

Other Please Specify:

ONCOGENETICS

TEST NAME	CODE	SELECT
Chromosome Analysis/ Bone Marrow (Cytogenetic Bone Marrow)	KARYB	☐
Philadelphia Chromosome (Whole Blood)	PHILB	☐

TEST NAME	CODE	SELECT
Philadelphia Chromosome (Bone Marrow)	PHIL	☐

Other Please Specify:

Other Tests Required _____

SAMPLE DETAILS

Specimen Collection Date: _____/_____/_____/ Specimen Type: _____

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

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CLINICAL INFORMATION

Please note that full clinical information is mandatory: *Please specify the condition/syndrome suspected clinically, if known*

HAEMATOLOGICAL KARYOTYPE

Indication (necessary for conclusive interpretation)

Acute Leukaemia (AL): ☐
- Acute Lymphoid Leukaemia (ALL) ☐
- Acute Myeloid Leukaemia (AML) ☐

Chronic Myeloid Leukaemia ☐
Chronic Lymphoblastic Leukaemia ☐
Lymphoma ☐
Myeloma ☐
Myelodysplastic syndrome (MDS) ☐
Myeloproliferative syndrome ☐
Fanconi anemia ☐
Recent bone marrow transplant ☐

Other (specify): _____ ☐

Immuno:_____

FAB Type: _____

CONSTITUTIONAL KARYOTYPE

In Infants
Small Birth Weight ☐ Sexual Ambiguity ☐
Hypotonia ☐ Dysmorphic Syndrome ☐
Malformation Syndrome ☐

In children
Developmental Delay ☐ Psycho-Motor Delay ☐

In adolescents
Girls: Delayed Puberty ☐ Boys: Gynecomastia ☐
Boys: delayed puberty ☐

In adults:
Multiple miscarriages: ☐ Number: _____
Sterility or hypofecundity ☐
Male infertility / abnormal sperm ☐
Primary or secondary amenorrhea ☐
Pre IVF ☐
Pre ICSI ☐

IMPORTANT: Please note that in accordance with good clinical practice we will automatically perform additional tests for an accurate diagnosis where required. This will incur further charges and, where applicable, please ensure your patient is aware of this. We recommend that you obtain signed consent from the patient that they will accept such charges.

INFORMED CONSENT SECTION

- **Patient or Guardian:**

I/we the undersigned confirm that I/we have been fully informed by the Doctor/Pathologist/ Geneticist _____ regarding cytogenetic and/or molecular genetic tests that will be performed on cells and/or DNA extracted from my/our child's blood and/or tissue to:

- o confirm or exclude the diagnosis of or a predisposition to a genetic disease.
- o determine heterozygote status with a view to obtaining genetic counselling.
- o examine gene locus/loci.

I/we give my/our consent to such testing and confirm that I/we have received all the necessary information according to the law.

Patient/Guardian Signature: _____ Date: _____/_____/_____

- **Doctor/ Pathologist/Genetic Consultant**

The Cytogenetic and/or molecular genetic test information is to be given by the Clinical Pathologist prescribing the test, or by the Physician collecting the sample. All relevant issues regarding the involved pathology etiology, development, prognosis and potential treatment must have been raised by the Genetic consultant or the Physician and clearly understood by the patient. All information associated with the patient file will be retained by Eurofins Biomnis. The result will be reported to the Physician only.

Doctor/Pathologist Signature: _____ Date: _____/_____/_____