REQUISITION FORM FOR GENETIC DISEASES AND PHARMACOGENETICS

GENOMED
Está nos genes.

REFFERING DOCTOR (MANDATORY):

Name (or print label):	ID number:
Hospital:	Service:
E-mail:	Telephone:
Signature:	Date: _____/_____/_____

Do you authorize the report to be sent by e-mail? Yes ☐ No ☐

If yes, please write your institutional e-mail address: _____

PATIENT IDENTIFICATION (MANDATORY):

Name:	Gender: F ☐ M ☐
Identification number:	Date of birth: _____/_____/_____

GenoMed use only:

Post label(s)

Conferred by:

CLINICAL DATA AND DIAGNOSIS*

Affected ☐ **Not affected (Asymptomatic)** ☐ Ideal expected date: _____/_____/_____

*Attach, whenever possible and can be justified, any relevant clinical information, family data including consanguinity, other cases in the family, family tree, etc.

FAMILIAL INFORMATION

Index case (affected) ☐ **Familial variant*** ☐ **Spouse** ☐

Known familial variant? NO ☐ YES ☐

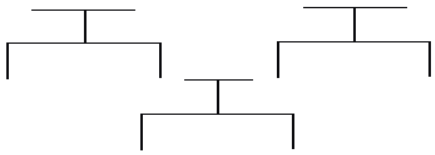
If yes*: Gene/RefSeq: _____/_____ Variant: _____

Was the index case studied at GenoMed? NO ☐ YES ☐

*For carrier studies and predictive testing (familial variant study), please attach a copy of the index case, whenever possible and applicable.
According to the Portuguese law, (article 9º, law nº 12/2005), carrier studies and predictive testing (conducted in healthy individuals) it is ESSENTIAL that the clinical geneticist makes the request and that the patient informed consent is obtained.

Information for Pedigree construction:

☐ Man ○ Woman ■● Affected ◧◑ Carrier ⊘ Deceased ○ Consanguinity ↗ Index case



SAMPLE	COLLECTION
Blood (EDTA) ☐ DNA ☐ Tumor ☐ ____% (infiltration percentage)	Date: _____/_____/_____
Other (specify) ☐ _____	Hour: _____:_____

INFORMED CONSENT (to be filled by the referring doctor)

I hereby declare that the patient informed consent for diagnosis was obtained.	YES ☐	NO ☐
I hereby declare that the patient informed consent for investigation was obtained.	YES ☐	NO ☐

CONTACT PERSONS: Dr.ª Diana Antunes, MD (dianaantunes@medicina.ulisboa.pt) / Dr.ª Ana Coutinho, PhD (anacoutinho@medicina.ulisboa.pt) Ext. 47301/47308

GenoMed, Diagnósticos de Medicina Molecular SA
Instituto de Medicina Molecular
Faculdade de Medicina da Universidade de Lisboa

Edifício Egas Moniz
Av. Prof. Egas Moniz
1649-028 LISBOA
PORTUGAL

Tel: (351) 21 799 95 01
Fax: (351) 21 799 95 00
E-mail: genomed@genomed.pt
www.genomed.pt

REQUISITION FORM FOR GENETIC DISEASES AND PHARMACOGENETIC

GENOMED
Está nos genes.

GENETIC TEST REQUIRED*

☐ **Disease/Gene(s)**: _____

☐ **Study for familial variant** *(specify at "familial information")*

☐ **NGS genetic panel** *(panel name)*: _____

☐ Additional genes *(if you want to personalize the above panel please specify which genes do you want to add or remove)*: _____

_____

_____

☐ With CNVs analysis** (*applicable to tests/panels with that option, marked at attachments I and II. For other CNVs studies, please contact us*)

**Additional cost.

☐ **Additional NGS genes analysis** (based on total exome) for:

☐ NGS panel *(panel name)*: _____

☐ Gene(s) *(specify)*: _____

_____

_____

_____

☐ Clinical Exome (single) *(mandatory to fill in the "additional informed consent" – "information leaflet/Informed consent" – attachment III)*

☐ With CNVs analysis** (*applicable to testes/panels with that option, marked at attachments I and II. For other CNVs studies, please contact us)*

**Additional cost.

☐ **Clinical Exome (single)** *(mandatory to fill in the "additional informed consent" – "information leaflet/Informed consent" – attachment III)*

☐ With CNVs analysis**

☐ **Clinical exome (trio)** *(mandatory to fill in the "additional informed consent" – "information leaflet/Informed consent" – attachment III)*

☐ With CNVs analysis**

**Additional cost.

☐ **DNA extraction**

☐ **Other studies***: _____

_____

***See attachment I and/or II from our requisition or consult our website. If the test you want isn't listed, please contact us.**

INFORMED CONSENT (mandatory – to be filled by the patient)

I hereby declare to authorize the collection of mine/my _____ [affiliation], _____ [name], born on _____/_____/_____, to the execution of the genetic testing described above, whose purposes and limitations were explained by the aforementioned physician. Herewith I declare that I have been informed about the consequences resulting from the teste results. I agree that the sample may be stored in order to allow repetition of the tests or further related tests at GenoMed or authorized partners around the world. The data/test results are subject to medical confidentiality and should only be disclosed to family members or other physicians with my permission. I am entitled to revoke this consent at any time.

☐ Agree ☐ Not agree

I also declare that the data/test results may be used in scientific investigations and publications in an anonymized form when and only approved by the Ethics Committee.

☐ Agree ☐ Not agree

(According to the Direction of General Health Standard nº 015/2013 updated.)

Patient's signature: _____ **Date:** _____/_____/_____

GenoMed, Diagnósticos de Medicina Molecular SA
Instituto de Medicina Molecular
Faculdade de Medicina da Universidade de Lisboa

Edifício Egas Moniz
Av. Prof. Egas Moniz
1649-028 LISBOA
PORTUGAL

Tel: (351) 21 799 95 01
Fax: (351) 21 799 95 00
E-mail: genomed@genomed.pt
www.genomed.pt