

# REQUISITION FORM FOR GENETIC DISEASES AND PHARMACOGENETICS

## REFERRING 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: \_\_\_\_\_

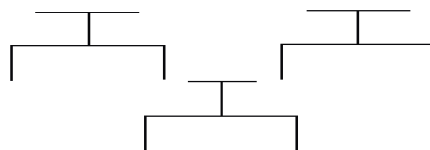
Was the index case studied at GenoMed? NO  YES

\*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

Blood (EDTA)  DNA  Tumor  \_\_\_\_\_% (infiltration percentage)  
Other (specify)  \_\_\_\_\_

## COLLECTION

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
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

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# REQUISITION FORM FOR GENETIC DISEASES AND PHARMACOGENETIC

## GENETIC TEST REQUIRED\*

- Disease/Gene(s):** \_\_\_\_\_
- Study for familial variant** (specify at "familial information") \_\_\_\_\_
- NGS genetic panel, with CNVs analysis** (panel name): \_\_\_\_\_
- Additional genes (if you want to personalize the above panel please specify which genes do you want to add or remove): \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- Additional NGS genes analysis, with CNVs 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 I)
- Clinical Exome (single), with CNVs analysis** (mandatory to fill in the "additional informed consent" – "information leaflet/Informed consent" – attachment I)
- Clinical exome (trio), with CNVs analysis** (mandatory to fill in the "additional informed consent" – "information leaflet/Informed consent" – attachment I)
- DNA extraction**
- Other studies\*:** \_\_\_\_\_
- \_\_\_\_\_

\*Please consult our website at [www.genomed.pt](http://www.genomed.pt). If the test you want isn't listed, please contact us.

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

I hereby declare that I have read the Privacy Policy of GenoMed® - Diagnósticos de Medicina Molecular, S.A., available at <https://genomed.pt/en/privacy-and-cookies-policy/> and I give my consent to the processing of the personal data.

Agree  Not agree

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:** \_\_\_\_\_

