eurofins | Biomnis

Test request form
Pharmacogenetics

INTERNATIONAL DIVISION
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Invoicing	Client no.	Your references
☑ Laboratory		

Laboratory's stamp or bar code sticker

REFERRING PHYSICIAN

Physician's stamp

Last name: ..... First name: .....

Address: .....

Postal code: ⌊⌊⌊⌊⌊ City: ..... Country: .....

Tél. : ⌊⌊ ⌊⌊ ⌊⌊ ⌊⌊ ⌊⌊ Fax : ⌊⌊ ⌊⌊ ⌊⌊ ⌊⌊ ⌊⌊

PATIENT

Last name* : ..... First name* : .....

Birth name* : .....

Date of birth*/** : ⌊⌊ ⌊⌊ ⌊⌊⌊⌊ Gender* : ☐ F ☐ M

**Required fields*

**If the patient is a minor, consent must be given by the holders of parental authority.

Date of sampling: ⌊⌊ ⌊⌊ ⌊⌊⌊⌊

Type of sample: .....

REQUEST FOR MOLECULAR GENETICS ANALYSES (analysis code)

☐ **Extended pharmacogenetic passport (all genes) (EPGX)**

☐ **Pharmacogenetic option on an exome already sequenced by our laboratory (PGX)**

Please indicate the reference of the exome file concerned: .....

☐ **Targeted pharmacogenetic analysis:**

Anti-cancer and immunosuppressive drugs:

- ☐ Azathioprine/ Mercaptopurine - TPMT **(TPMT)**
- ☐ 5FU / Capecitabine - DPYD **(5FUGE)**
- ☐ Irinotecan - UGT1A1 **(UGT1A)**
- ☐ Tacrolimus - CYP3A5/ CYP3A4 **(EPGX)**

Cardiovascular drugs:

- ☐ Mavacamtem - CYP2C19 **(CYP2C)**
- ☐ Clopidogrel - CYP2C19 **(CYP2C)**
- ☐ AVK - CYP2C9/ VKORC1/ CYP4F2 **(EPGX)**

Anti-infectious drugs:

- ☐ Voriconazole - CYP2C19 **(CYP2C)**
- ☐ Abacavir - HLA-B*57:01 **(HLA1)**

Anti-epileptic drugs:

- ☐ Carbamazepine - HLA-B*15:02/ HLA-A*31:01 **(HLA1)**
- ☐ Phenytoin - CYP2C9 **(EPGX)**

Urea-lowering medication:

- ☐ Allopurinol - HLA-B*58:01 **(HLA1)**

Other (EPGX):

- ☐ Please specify the name(s) of the genes: .....

PATIENT INFORMATION

Treatments in progress: .....

.....

Upcoming treatments: .....

.....

CONSENT FOR AN EXAMINATION OF A PERSON'S GENETIC CHARACTERISTICS

(In accordance with French articles R.1131-4 and R.1131-5 of the French Public health code).

I, the undersigned .....

.....

born on ⌊⌊ ⌊⌊ ⌊⌊⌊⌊

▸ **hereby declare that I had consultation with Dr:**

.....

where information on the genetic tests to be performed for the reasons listed below was provided:

☐ assess genetic susceptibility to disease or drug treatment.

▸**To this end, I consent:**

☐ to the sample to be taken from my home

☐ to the deduction that will be made from my minor child or a person of full age under guardianship for whom I am the legal representative

I am informed that the results of the examination of the genetic characteristics will be transmitted to me by the above-mentioned Doctor in the framework of an individual consultation. If the examination reveals results other than those sought, the aforementioned Doctor will determine the appropriate course of action during an individual consultation.

▸ **If part of the sample remains unused after examination:**

☐ I agree that it may be integrated, if necessary, for scientific research purposes. In this case, all medical data concerning me will be protected by complete anonymisation. Consequently,I am aware that these scientific studies carried out will not be of any benefit or prejudice to me.

Signed in (city) .....

on ⌊⌊ ⌊⌊ ⌊⌊

Patient's signature, signature of the holders of the parental authority of the child or the guardian of the adult under guardianship:

DECLARATION OF CONSULTATION

(French Decree n° 2008-321 dated 4 April 2008 - French Decree dated 27 May 2013).

I, the undersigned .....

R.1131-4 and R.1131-5 of the French Public Health Code, hereby certify that the patient mentioned above was received for a consultation today where information on the characteristics of the disease to be screened, the methods used to detect it and details on the possibilities of prevention and treatment were provided.

Signed in (city).....

on ⌊⌊ ⌊⌊ ⌊⌊

Physician's signature:

B110-INTGB - October 2024