eurofins | Biomnis

Test request form
Constitutional molecular genetics

INTERNATIONAL DIVISION
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Customer number:

Date : ⌊__⌋⌊__⌋⌊__⌋
EDTA whole blood sample

Laboratory's stamp or bar code sticker

PRESCRIBING CLINICIAN

First name(s): ..... Surname : .....
Address: .....
Post code: ⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋ City : ..... Country: .....
Tel.: ⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋ Fax: ⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋

PATIENT

First name(s): ..... Surname : .....
Birth name: .....
Date of birth* : ⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋ Gender: ☐ F ☐ M
Address: .....
Post code: ⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋ City: .....
Country: ..... Tel.: ⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋

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

CLINICAL SIGNS -*This section must be completed*

.....

Date of sampling: ⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋

SAMPLE TYPE - *This section must be completed*

☐ EDTA whole blood ☐ Other - *please specify* : .....

MOLECULAR GENETICS TEST REQUEST FORM

☐ Alpha 1-antitrypsin (S and Z variants) **(A1BM)**
☐ Amylose héréditaire à transthyrétine : Etude du gène TTR **(TTR)**
☐ Angelman syndrome **(Postnatal: SNRPS / Prenatal : SNRPL)**
☐ Uniparental disomy **(DUPRE)**
☐ Exome **(EXOME)**: *specific request form required, please see www.eurofins-biomnis.com*
☐ Factor II (mutation g.20210G>A) **(F2M)**
☐ Factor V Leiden (mutation p.Arg506Glu) **(F5L)**
☐ Familial Mediterranean Fever (FMF) - study of the MEFV gene **(FMF)**: *please attach the completed clinical information form which is available on www.eurofins-biomnis.com*
☐ CYP2C19 *2/*3 alleles genotyping **(CYP2C)**
☐ ApoE genotyping **(APEBM)**, in the context of: ☐ dyslipidemia ☐ neurodegenerative disease
☐ DPD genotyping **(5FUGE)**
☐ IL-28B genotyping **(IL28B)**
☐ RHD genotyping **(BMGR)**
☐ Gilbert syndrome (polymorphism UGT1A1*28) **(GILB)**
☐ Haemochromatosis: mutation p.Cys282Tyr **(HMC)**
☐ Haemochromatosis: mutation p.His63Asp **(H63D)**
☐ Haemochromatosis: mutation p.Ser65Cys **(S65C)**
☐ HLA class I - HLA-C genotyping **(HLCT)**
☐ HLA class I (loci A, B) **(HLA1)** : ☐ A*29 ☐ B*27 ☐ B*51 ☐ B*57
☐ HLA classe II (loci DQ, DR) **(HLA2)** : ☐ DR4 ☐ DQ2 ☐ DQ8 ☐ DQB1*0602
☐ HLA-B*27 **(B27BM)**
☐ Lactose intolerance **(LCT)**
☐ Y chromosome microdeletions (loci AZFa, AZFb and AZFc) **(DELY)**
☐ MTHFR (Methylene Tetrahydrofolate Reductase - thermolabile variant, mutation c.677C>T) **(MTHFR)**
☐ MTHFR (Methylene Tetrahydrofolate Reductase, mutation c.1298A>C) **(MTHF2)**
☐ MUC1 Variation 27dupC **(MUC1)**
☐ Cystic fibrosis (CFTR, screening of most frequent mutations) **(MUCO)** :
specific request form required, please see www.eurofins-biomnis.com
☐ Prader-Willi syndrome **(Postnatal: SNRPS / Prenatal: SNRPL)**
☐ DNA microarray (SNP array) **(SNPRE)**
☐ qPCR: *contact us* **(QPOST)** *(attach the R66-INTGB information form)*
☐ Sanger: *contact us* **(SEPOS)** *(attach the R66-INTGB information form)*
☐ Fragile X syndrome **(Postnatal: XFRA / Prenatal: XFRAP)**
☐ UGT1A1 - Evaluation of the toxic risk of irinotecan **(UGT1A)**
☐ Other - *please specify*: .....

CONSENT PRIOR TO THE CARRYING OUT OF GENETIC EXAMINATIONS OF AN INDIVIDUAL

(In accordance with Articles R.1131-4 and R.1131-5 of the 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:

☐ to confirm or invalidate the diagnosis of a genetic disease in relation to my symptoms, those of my minor child or those of the adult person under guardianship for whom I am the legal representative;
☐ confirm or deny the pre-symptomatic diagnosis of a genetic disease;
☐ to identify a healthy carrier status (heterozygous or chromosomal rearrangement);
☐ 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 MEDICAL CONSULTATION

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

I, the undersigned .....
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: