eurofins | Biomnis

Test request form
Cytogenetics

INTERNATIONAL DIVISION

17/19, avenue Tony Garnier - BP 7322 - 69357 Lyon cedex 07
Tel.: **+33 (0)4 72 80 23 85** - Fax: **+33 (0)4 72 80 73 56**
E-mail: **international@eurofins-biomnis.com**

Customer Identification

Compulsory Stick your laboratory identification sticker here

Date : |_|_| |_|_| |_|_|
Heparin whole blood sample

Customer number

PRESCRIBING CLINICIAN

First name(s): ..... Surname: .....
Address: .....
Post code: |_|_|_|_|_| City: .....
Country: .....
Tel.: |_|_| |_|_| |_|_| |_|_| |_|_| Fax: |_|_| |_|_| |_|_| |_|_| |_|_|

Physician's stamp

PATIENT

First name(s): ..... Surname: .....
Date of birth* : |_|_| |_|_| |_|_|_|_| Gender: ☐ F ☐ M
Address: .....
Post code: |_|_|_|_|_| City: .....
Country: ..... Tel.: |_|_| |_|_| |_|_| |_|_| |_|_|

** If the patient is a minor, consent must be given by the parents.*

INDICATIONS *This information must be given*

☐ Mental retardation, dysmorphic syndrome, developmental defects

Please specify:.....

☐ Reproduction difficulties - *Please specify:* .....

☐ Familial studies: *Please enclose a copy of the index case and degree of consanguinity*

☐ Other - *Please specify:* .....

☐ Breakage syndrome - *Please specify:* .....

CYTOGENETIC TEST REQUEST

☐ Standard/constitutional karyotype **(CSG)**
Heparin whole blood sample

☐ Molecular karyotype (DNA microarray - SNP array) **(SNPOS)**
EDTA whole blood sample

☐ Fluorescent *in situ* hybridisation screen (FISH) **(RCPOS)**

Please specify: .....

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

(Pursuant to articles R. 1131-4 and R. 1131-5 of the French Public Health Code).

I, the undersigned .....
born on |_|_| |_|_| |_|_| ***hereby declare that I had a consultation with Dr:***
.....
where information on the genetic tests to be performed for the reasons listed below was provided:

☐ *To confirm or otherwise the diagnosis of a genetic disease in relation to my symptoms,*
☐ *To confirm or otherwise the pre-symptomatic diagnosis of a genetic disease,*
☐ *To identify the healthy carrier status of an individual (heterozygote screen or chromosomal rearrangement),*
☐ *To assess my genetic susceptibility of being afflicted with a genetic disease or undertaking a medical treatment.*

As such, I consent to:

☐ *sample(s) being collected from me.*
☐ *sample(s) being collected from my child (for minors) or an adult under guardianship.*
☐ *sample(s) being collected from my fœtus.*

I have been informed that the results of these genetic tests will be communicated to me by the aforementioned Doctor during an individual consultation. If the exam reveals any results other than those specified on the original request, the aforementioned Doctor will determine the appropriate steps to be taken during the individual consultation.

Should any of the sample remain unused following examination:

☐ *I consent to this sample being used, if needs be, for scientific research purposes. In this case, all personal medical data will be protected by it being made totally anonymous. Consequently, I am conscious that the scientific studies performed will not provide me with any advantage or prejudice.*

Signed in (city) .....
on |_|_| |_|_| |_|_|

Patient's signature, signature of a legal representative of a child or signature of a legal guardian for an 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:

B13-INTFR - November 2020