Date, time and the signature of the person accepting the order on behalf of MEDGEN

ul. Wiktorii Wiedeńskiej 9A
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ORDER FORM FOR THE GENETIC TESTING

PATIENT INFORMATION
First and last name (*capital letters*):

……………………………………………………………………
……………………………………………………………………

Date of birth (day/month/year):………/………/……..

PESEL(identification no.): _ _ _ _ _ _ _ _ _ _ _

Sex: female ☐ male ☐ unknown ☐

Ethnic origin: ☐ Polish ☐ other ………………………

Contact address:…………………………………………..
……………………………………………………………………

Contact phone number:…………………………………..

Number of the patient's card in the referring/requesting unit:……………………………………………………….

Fill in if the patient directed to the test is related to a person that has been previously directed to the test.

First and last name
……………………………………………………………………

REQUESTING UNIT INFORMATION

Name of the unit:……… ……………………………………...
……………………………………………………………………
……………………………………………………………………

Address:……………………………………………………...
……………………………………………………………………
……………………………………………………………………

Telephone:……………………………………………………

Fax:……………………………………………………………...

NIP:……………………………………………………………..

Full name of the referring/requesting physician:
……………………………………………………………………..

Contact phone number:……………………………………..

E-mail:…………………………………………………………..

SAMPLE INFORMATION
Type of material:
- ☐ blood spot
- ☐ peripheral blood
- ☐ amniotic fluid
- ☐ trophoblast
- ☐ bone marrow
- ☐ isolated DNA
- ☐ other…………………………………………………………….

Date and hour of sample collection
(day/month/year): ………/……..…/…………..hour…………………

Data of the person who collected the sample material:
…………………………………………………………………………….

TEST INFORMATION :

Name of the disease:………………………………………………

Procedure code:……………………………………………………

ADDRESS TO WHICH THE RESULT SHOULD BE SENT OR THE DATA OF THE PERSON AUTHORIZED TO COLLECT IT

The result is usually sent to the requesting unit. If you would like to receive it elsewhere, please give the specific address below:
…………………………………………………………………………………
…………………………………………………………………………………
…………………………………………………………………………………
…………………………………………………………………………………

INVOICE INFORMATION (only if other than the information of the requesting unit): NIP:……………………………………………..

Full name/ name of the requesting unit/name of the company:
…………………………………………………………………………………
…………………………………………………………………………………

Address:……………………………………………………………………..
…………………………………………………………………………………
…………………………………………………………………………………

Information covered by professional secrecy (physician and the laboratory diagnostician):

Without the following information the material will not be analysed:

Aim of the test:

☐ Prenatal diagnostics
☐ Postnatal diagnostics
☐ Verification of the clinical diagnosis
☐ Determination of the carrier status
☐ Determination of the patient's predisposition to the genetic disease mentioned above
☐ Presymptomatic diagnostics
☐ Postmortem diagnostics
☐ Securing genetic material
☐ Other…….

Indications/Reasons for performing the test:

……..
……..
……..
……..
……..

karyotype: ☐ correct ☐ incorrect(what?.....) ☐ has not been tested

Has a genetic test ever been done before? ☐ yes ☐ no

If YES, where was it performed (e.g. in what clinic) and what was the target disease:

.....

Did any genetically conditioned diseases ever occur in the family? ☐ yes ☐ no

If YES, please name the diseases and the degree of kinship with the proband/the affected person and the full name of the proband/affected person……..……..

.....

INFORMATION ABOUT TRANSFUSION AND HEMATOPOIETIC STEM CELL TRANSPLANTATION

☐ no ☐ yes. If YES, when did it take place ……...……

* genetic testing should not be performed until 3 months after a transfusion, otherwise the obtained diagnostic result may be incorrect.

…… ……
date Signature and stamp of the referring physician

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DECLARATION OF INFORMED CONSENT FOR THE GENETIC TEST

Fills an adult patient or parent/legal guardian of the patient

First and last name	
PESEL (identification no.) of the patient:	
Contact phone number:	**E-mail:**
Contact address:	

The material collected from me or my child (please choose the correct option):
☐ **blood** ☐ **tissue** ☐ **amniotic fluid** ☐ **trophoblast** ☐ **other (……..)**

will be used for molecular diagnostics based on DNA analyzing towards:

……

Name of the disease and the procedure code

I am aware that:

1. The collected material will be used for DNA isolation and performing:
   - ☐ prenatal diagnostics (before birth)
   - ☐ postnatal diagnostics (after birth)
     - ☐ determination of carrier status
     - ☐ verification of the clinical diagnosis
     - ☐ determinationof the patient's predisposition to the genetic disease mentioned above
2. Isolated DNA will be stored in specific and appropriate conditions however, there is a risk of DNA degeneration (which is a natural process). Therefore another collection of the material might be needed.
3. If the kinship between family members is different than declared, the result of the genetic test may be incorrect
4. If the patient becomes an adult during the genetic diagnosis (from collecting the material to the result of the test), he will be obligated to sign the DECLARATION OF INFORMED CONSENT FOR THE GENETIC TEST.
5. If in the last 2 months before the material collection to the genetic test I/my child had a transfusion, I will inform the worker of Centrum Medyczne MedGen. Not informing the Centrum Medyczne MedGen worker about the transfusion may lead to an incorrect result of the genetic test.
6. DNA preparation is normally stored in the DNA bank of Centrum Medyczne MedGen. Thanks to such a solution, it is possible to perform additional tests for the Patient.
   - ☐ **I AGREE TO STORE MY/MY CHILD'S DNA**
   - ☐ **I DO NOT AGREE TO STORE MY/MY CHILD'S DNA**
7. I have recieved the information referred to in art. 9 ust. 2 ustawy z dnia 23 marca 2017 r. from the doctor who ordered the test, about the patient rights and Patient's Rights Ombudsman (Dz. U. z 2017 r. poz. 836, z późn. zm.), in particular about the essence of the suspected disease and the diagnostic significance of the planned genetic test.

I, the undersigned, hereby agree to the processing of my personal data/the personal data of my Child, by CM MedGen headquartered in Warsaw, (hereinafter "the Administrator ") in order to perform the genetic tests. Data submission is voluntary, but necessary to perform the genetic tests. The basis for data processing is my consent. Data users are: the Administrator and: …….. I have the right to withdraw the permission at any time. Personal data will be processed until the consent is withdrawn. After such a cancellation for the period of limitation of claims of the data controller and in relation to him. I have the right to obtain from the administrator the access to my personal data, the rectification of inaccurate personal data, removing them or restriction of processing them, and the right to the supervisory authority.

……

Place and date | Signature of the referring physician | Signature of the patient (if over 18) / parent / legal guardian

……

Signature of the underage patient if over 16

Full name of the Patient:……

PESEL of the Patient(identification no.): ……

AUTHORISATION

I, ...,
Full name of the Patient/Legal guardian

with the PESEL/identification no. :.....,

I authorize Mrs/Miss/Mr .....,
Full name

resident in……..……..., phone number: ……
to access my/my child's health information.

.....
Full name of the Patient/Legal guardian, date

I authorize: Mrs/Miss/Mr .....
Full name

resident in....., phone number: .....
to access my/my child's medical records, regarding state of health and health services provided:

.....
Full name of the Patient/Legal guardian, date

I do not authorize any person to access the information about my/my child's state of health and the medical records, regarding my/my child's state of health, and health services provided.

.....
Full name of the Patient/Legal guardian, date

Na podstawie Rozporządzenia Ministra Zdrowia z dnia 09/11/2015 r. w sprawie rodzajów i zakresu dokumentacji medycznej oraz sposobu jej przetwarzania (Dz.U. 2015 nr 2069).