

REQUISITION FORM

A. Gencik MD, PD
Specialist for Human Genetics

Dr. rer. nat. H. D. Gabriel
Clinical geneticist, GfH

Tel: 0049 541 80019903
Fax: 0049 541-80019905
info@diagenos.com
www.diagenos.com

diagenos

Caprivistr. 30
49076 Osnabrück
GERMANY

Patient identification

Sample type: DNA blood buccal swab other: _____

Last Name: _____ First Name: _____ Date of Birth: _____

Hospital/Patient ID # _____ Gender: male female

Ethnic origin: _____ Country of Birth: _____

Indication for test, family history: _____

Short clinical description (optional): _____

Requesting physician /clinic

Last Name: _____ First Name: _____

Name of the Institution/Clinic: _____

Address: _____

Country: _____

e-mail: _____ Phone: _____ Fax: _____

Payment: invoice in advance CreditCard PayPal

Date: _____ Physician Signature: _____

Requested analysis

Disease name: _____ Synonym: _____

Gene symbol: _____ OMIM: _____

Other: _____

Consent to genetic testing

Patient

Last Name: _____ First Name: _____ Date of Birth: _____

I hereby agree that genetic testing will be performed on me / my child and that the material will be stored for review of results and for any additional test that may be necessary to obtain a clear result or for research on the above mentioned disorder..

(Place/Date)

(Signature of Patient/Parent)

(Name, Stamp of Physician)

(Signature of the Physician)