

## Request for Genetic Testing – Clinical EXOME – Blood Relatives of the Proband

Personal Data of the Examined Person (Label):	Referring Physician:
Name and surname: Insurance number: Date of birth: Insurance company:                      Self-payer Gender:                      Male              Female Address:  Diagnosis (ICD):	         (name, specialty, NPI, workplace, stamp, signature)
Primary Sample:	Other Material:
<b>Peripheral blood</b> (5ml non-coagulated blood in K3EDTA)  Buccal swab (2x special swab sticks - supplied upon request by the laboratory)	Isolated DNA from:
Date and Time of Collection:	Date and Time of Indication (if different from the collection date and time):
Clinical Data (to be completed by the referring physician):	
Does this person have the same condition as the proband?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Proband (patient indicated for exome examination):	
Name and surname:	Date of birth:
Relationship of the examined person to the proband:	
Informed Consent* – Examined Person:	
AGREES                      with examining the sample with using the sample for research purposes with storing the sample	DISAGREES                      with storing the sample
*) By submitting the request, the referring physician confirms that the patient or legal representative has signed the Informed Consent, which is either stored in the patient's documentation or attached to this request.	
<b>Examination conducted by:</b> GENNET, Ltd., GENNET Laboratories, Pekařská 635/6, 158 00 Prague 5 - Jinonice, Tel: 226 231 691	
Laboratory records:	
Date and time of sample/referral receipt:	Sample/referral received by:

