MEDICARE DIAGNOSTIC CENTER

GENETIC TEST REQUEST FORM

Patient's name: .....

Patient's gender: ☐ male ☐ female

Date of birth: .....

Social Security number: .....

Sender's name: .....

Sender's contact information: .....

Billing name: .....

Billing address: .....

Time of sampling: ..... (day) ..... (month) ..... (year)
..... (hour) ..... (minute)

Sample type: ☐ EDTA blood (purple cap) ☐ Heparin tube
☐ Oral mucosa swab ☐ CWBio tube (for Septin9 test)

Pregnancy: ☐ yes ☐ no

Other information about the sample: .....

MEDICARE DIAGNOSTIC CENTER LABORATORY TESTS

☐	APOB - Familial hypercholesterolemia R3500Q PCR
☐	APOE - Alzheimer's disease predisposition screening
☐	Factor V Leiden mutation
☐	Factor II (prothrombin) G20210A mutation
☐	MTHFR - C677T mutation and A1298C mutation MTRR mutation and MTR gene mutation (folate metabolism)
☐	Lactose intolerance C13.9kbT and G22018A
☐	Celiac disease (HLA)
☐	HLA B27
☐	BRCA (NGS)
☐	PAI-1 gene polymorphism
☐	Haemochromatosis panel (HFE C282Y, HFE H63D)
☐	Genetic variations predisposing to blood clotting disorders
☐	Thrombophilia narrowed genetic panel (F5:Leiden, F2:Prot., MTHFR677, MTHFR1298)
☐	Y chromosome microdeletion PCR test (AZF)

OTHER GENETIC TESTS

☐	Septin 9 + panel – ColonalQ (Colon tumour screening with molecular testing)
☐	X and Y chromosome aneuploidy
☐	CBS 844ins68 mutation
☐	Cytogenetics, karyotyping
☐	Cystic fibrosis (139 mutation)
☐	Carrier screening for SMA

GENERAL QUESTIONS, REQUEST FOR A QUOTE:
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LOGISTICS, EQUIPMENT REQUEST:
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STATEMENT OF CONSENT FOR GENETIC SAMPLING

I, the undersigned, consent to the taking of a sample for performing the genetic test indicated on this application form, and to the storage of my genetic sample, my personal identification data and the genetic data obtained from the test together, in accordance with the requirements of the applicable data protection legislation.

Date: ....

signature of the person concerned, or in the case of a person of limited legal capacity, the signature of his/her legal representative

I declare that I am having the test performed on the recommendation of my doctor or genetic counselor, that during the consultation procedure, I was informed by a person authorized by law, before the sample was taken, about the purpose of the sample, the benefits and risks of performing or not performing the test, the possible consequences of the possible results for myself and my close relatives, and that I will visit my doctor and/or genetic counselor for a detailed discussion with the results, and – if necessary – participate in genetic counseling.

Date: ....

signature of the person concerned, or in the case of a person of limited legal capacity, the signature of his/her legal representative

I understand that the genetic sample may be transferred to another laboratory, if necessary, for the purpose of performing the requested test, in accordance with data protection regulations. Detailed information on sample and data transfer can be found in the Privacy Policy on the medicarelabor.hu website.

Date: ....

signature of the person concerned, or in the case of a person of limited legal capacity, the signature of his/her legal representative

I, the undersigned, **consent/do not consent*** to the use of DNA isolated from my sample in a manner that is permanently unsuitable for personal identification for method development and quality assurance purposes, if necessary. *Underline the appropriate part

Date: ....

signature of the person concerned, or in the case of a person of limited legal capacity, the signature of his/her legal representative

We inform you that the primary test sample will be destroyed within 14 days after the results are issued, in the absence of the data subject's consent to its use for method development and quality assurance purposes, the DNA solution prepared from the primary sample will be destroyed within 30 days, the genetic data (only health data generated specifically as a result of the test) will be stored together with the personal identification data for 30 years in accordance with the law. I acknowledge that the genetic data may be communicated to me personally (as the data subject or the data subject's legal representative), my authorised representative, or to anyone who is entitled to access the genetic data under the relevant law. We inform you that your data will be processed in accordance with Act XLVII of 1997 on the processing and protection of health and related personal data, the General Data Protection Regulation (2016/679/EU – GDPR) and Act CXII of 2011 on the right to information self-determination and freedom of information, and Act XXI of 2008 on the protection of human genetic data, the rules of operation of human genetic testing and research and biobanks.

Date: ....

signature of the person concerned, or in the case of a person of limited legal capacity, the signature of his/her legal representative