

Biomnis Genetic Test Request, Information & Consent Form



PATIENT DETAILS

Surname: _____

Forename: _____

Date of Birth: ____/____/____

Sex: Male: Female:

Hospital/Clinic No.: _____

Laboratory No.: _____

Ward: _____

Physician: _____

REQUESTING HOSPITAL / CLINIC DETAILS

Hospital/Clinic Name: _____

Department: _____

Address: _____

Phone: _____ Fax: _____

PLEASE REMEMBER ALWAYS TO COMPLETE THE INFORMED CONSENT SECTION

TESTS REQUIRED

MOLECULAR GENETICS

TEST NAME	CODE	SELECT	TEST NAME	CODE	SELECT
Array CGH Analysis	CGH	<input type="checkbox"/>	Huntingtons Disease	HUNT	<input type="checkbox"/>
Chromosome Y Microdeletions	YQ	<input type="checkbox"/>	MTHFR Mutation C677T	MTHFR	<input type="checkbox"/>
Cystic Fibrosis Screen (most common mutations)	CF36	<input type="checkbox"/>	Muscular Dystrophy (Duchenne's)	DUCH	<input type="checkbox"/>
Factor V Leiden PCR	FAC5	<input type="checkbox"/>	Prothrombin (Factor II) Mutation	PTMUT	<input type="checkbox"/>
Fragile X Chromosome	FRAGX	<input type="checkbox"/>	Rett's Syndrome	RETT	<input type="checkbox"/>
Haemochromatosis	HFE	<input type="checkbox"/>			

CYTOGENETICS

TEST NAME	CODE	SELECT	TEST NAME	CODE	SELECT
Chromosome Analysis / Karyotyping - Whole Blood	KARY	<input type="checkbox"/>	Prader Willi Syndrome (15q11-13 Methylation)	PRADW	<input type="checkbox"/>
Chromosome Analysis – Products of Conception	KARPP	<input type="checkbox"/>	William's Syndrome	WILL	<input type="checkbox"/>

ONCOGENETICS

TEST NAME	CODE	SELECT	TEST NAME	CODE	SELECT
Chromosome Analysis/ Bone Marrow (Cytogenetic Bone Marrow)	KARYB	<input type="checkbox"/>	Philadelphia Chromosome (Bone Marrow)	PHIL	<input type="checkbox"/>
Philadelphia Chromosome (Whole Blood)	PHILB	<input type="checkbox"/>			

Other Tests Required: _____

SAMPLE DETAILS

Specimen Collection Date: ____/____/____ Specimen Type: _____

Biomnis Ireland Genetic Test Request, Information & Consent Form



Clinical Information Please note full clinical information is essential: Please specify the condition/syndrome suspected

clinically, if known: _____

HAEMATOLOGICAL KARYOTYPE

Indication (necessary for conclusive interpretation)

Acute Leukaemia (AL):

- Acute Lymphoid Leukaemia (ALL)
- Acute Myeloid Leukaemia (AML)

- Chronic Myeloid Leukaemia
- Chronic Lymphoblastic Leukaemia
- Lymphoma
- Myeloma
- Myelodysplastic syndrome (MDS)
- Myeloproliferative syndrome
- Fanconi anemia
- Recent bone marrow transplant

Other (specify): _____

Immuno: _____

FAB Type: _____

CONSTITUTIONAL KARYOTYPE

In Infants

- Small Birth Weight Sexual Ambiguity
- Hypotonia Dysmorphic Syndrome
- Malformation Syndrome

In children

- Developmental Delay Psycho-Motor Delay

In adolescents

- Girls: Delayed Puberty Boys: Gynecomastia
- Boys: delayed puberty

In adults:

- Multiple miscarriages: Number: _____
- Sterility or hypofecundity
- Male infertility / abnormal sperm
- Primary or secondary amenorrhea
- Pre IVF
- Pre ICSI

INFORMED CONSENT SECTION

• Patient or Guardian:

I/we the undersigned confirm that I/we have been fully informed by the Doctor/Pathologist/ Geneticist _____ regarding cytogenetic and/or molecular genetic tests that will be performed on cells and/or DNA extracted from my/our child's blood and/or tissue to:

- o confirm or exclude the diagnosis of or a predisposition to a genetic disease.
- o determine heterozygote status with a view to obtaining genetic counselling.
- o examine gene locus/loci.

I/we give my/our consent to such testing and confirm that I/we have received all the necessary information according to the law.

Patient/Guardian Signature: _____

Date: ____/____/____

• Doctor/ Pathologist/Genetic Consultant

The Cytogenetic and/or molecular genetic test information is to be given by the Clinical Pathologist prescribing the test, or by the Physician collecting the sample. All relevant issues regarding the involved pathology etiology, development, prognosis and potential treatment must have been raised by the Genetic consultant or the Physician and clearly understood by the patient. All information associated with the patient file will be retained by Biomnis Ireland. The result must be reported to the Physician only.

Doctor/Pathologist Signature: _____

Date: ____/____/____