



RESERVED  
CGC Genetics

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## GENETIC TEST REQUEST FORM POSTNATAL

ORDERING PHYSICIAN

PHYSICIAN'S NAME\*

DEPARTMENT

INSTITUTION\*

PHONE

EMAIL\*

CITY

COUNTRY

PATIENT INFORMATION

NAME\*

DATE OF BIRTH\* (dd/mm/yyyy)

MEDICAL RECORD NO.

GENDER\*

☐ female

☐ male

BILING INFORMATION (if receipt is issued on patient's behalf):

VAT No.

ADDRESS

ZIP CODE

CITY

COUNTRY

SAMPLE\*

BIOLOGICAL SAMPLE

☐ PERIPHERAL BLOOD

☐ DNA

☐ OTHER

COLLECTED AT

DATE AND TIME OF COLLECTION (dd/mm/yyyy)

### REQUESTED TEST\*

☐ Karyotype

☐ Array CGH 750 K

☐ Array CGH HD

☐ Familial mutation (attach index genetic report)

*Gene and mutation(s)*

*RefSeq*

☐ Sequencing of individual gene(s) *please specify*

☐ NGS Panel for *please specify*

Exome sequencing – Index case

☐ Disease Exome by CGC Genetics

☐ Whole Exome Sequencing (WES)

Exome sequencing – Trio

☐ Disease Exome by CGC Genetics

☐ Whole Exome Sequencing (WES)

☐ Other (MLPA/trinucleotide repeat expansions/FISH) – for other genetic tests please visit [www.cgccgenetics.com](http://www.cgccgenetics.com)

### CLINICAL INFORMATION\*

Please refer indication for the genetic test, provide clinical description and relevant family history. For carrier or pre-symptomatic testing, please attach a copy of the index case report.

*to be continued on the following page*

I certify that (i) the patient (or legal representative) has agreed to have this testing performed, by signing the patient informed consent, (ii) the patient informed consent is in agreement with the legal requirements and that (iii) I am providing CGC Genetics all relevant medical information indispensable for the testing to be performed.

I certify that (i) I was informed about the benefits, risks and limitations of the test to be performed, (ii) I put all the questions that I consider relevant and understood the answers provided. I give authorization to proceed with the requested genetic test and the use of the sample exclusively to this end.

☐ I agree

☐ I do not agree

*The sample can also be used for scientific research purposes.*

☐ I agree

☐ I do not agree

PHYSICIAN'S SIGNATURE \_\_\_\_\_  
(mandatory)

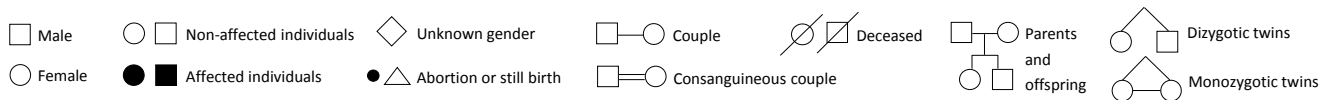
PATIENT'S SIGNATURE \_\_\_\_\_  
(to be used in case no other informed consent is available)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



## FAMILY TREE



**Patient rights.** The patient can request the right of access, modification and cancellation of the data provided by letter addressed to CGC Genetics, Clinical Director to [customercare@cgcgenetics.com](mailto:customercare@cgcgenetics.com).