

**Dres. med. Kläs / Cremer / Schulze / Jung**

Harrlachweg 1  
68163 Mannheim  
Germany

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Fax 0621-42286-88  
info@zhma.de  
www.zhma.de

Patient data

# Examination Request

## Sender

Hospital     Outpatient Clinic     Physician  
Address/Stamp    Phone \_\_\_\_\_  
Fax \_\_\_\_\_

Message to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Invoicing Address (if differing)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Material for Examination

<input type="checkbox"/> Heparin-Blood 5ml	<input type="checkbox"/> Abortion Tissue
<input type="checkbox"/> EDTA-Blood 5ml	<input type="checkbox"/> DNA
<input type="checkbox"/> Amniotic Fluid 15ml	<input type="checkbox"/> Buccal Swab
<input type="checkbox"/> clear <input type="checkbox"/> bloody <input type="checkbox"/> xanthochromic	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Chorionic Villus 25mg	
▶ Sampling: Date _____ Time _____	

*\* in case of prenatal molecular genetic diagnostic please extract more sample material and additionally send EDTA-Blood of the mother!*

## Indication / Examination

## Patient Information

Gender  f  m    Ethnic Origin \_\_\_\_\_  
(important e.g. for CF, FMF)

Medical History / Pedigree / Pre-Findings:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Gravida    \_\_\_\_\_ Para  
\_\_\_\_\_ Miscarriage    \_\_\_\_\_ Stillbirth

Pregnancy:  no  yes    \_\_\_\_\_ WoP+ \_\_\_\_\_ days

Adjusted after exam.: \_\_\_\_\_ WoP+ \_\_\_\_\_ days    \_\_\_\_\_ EDD

## Declaration of Consent

***The declaration of consent by the patient, respectively its (legal) representative is a prerequisite for the examination according to German law.***

With my signature and after having been dutifully informed, as well as being in full knowledge of my right of withdrawal, I confirm my consent to the planned genetic analysis and required sampling of blood / tissue.

The result does not need to be destroyed after 10 years as required by the legal provisions, to also remain available to my family for the time to come.

I hereby assign examination material remaining after the completion of the analysis acc. to paragraph 950 BGB to the laboratory responsible for the analysis.

I agree to the use of surplus examination material for the implementation of quality assurance (in anonymous form).

**Delete as applicable**

I furthermore agree to the transfer of the results to the address stated in "Message to:".

Place/Date

Signature of the Patient or (legal) representative

Signature of the responsible medical professional acc. to GenDG

## Sample Arrival (only to be completed by the ZHMA)

Material \_\_\_\_\_ Route \_\_\_\_\_ Amount \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

## Sender Address for Material (unchilled, no priority mail)

**Dres. med. Kläs / Cremer / Schulze / Jung**  
Specialists for Human Genetics

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