

Auftrag zur labordiagnostischen Syndromdiagnostik

PATIENT

Zuname:

Vorname:

männlich weiblich

SV-Nr.: _____ Geburtsdatum: _____

EINSENDER

Ansprechpartner (Druckschrift):

Telefon:

Abnahmedatum:

Unterschrift:

Klinikstempel/Praxisstempel:

KOSTENTRÄGER:

Einsender

Patient (*Bitte unbedingt vom Patienten unterschriebene **Kostenübernahmeerklärung** inkl. Kontaktadresse beilegen!*)

Screeninguntersuchungen

Chromosomen (5 ml Heparinblut)

CGH/SNP Array (2 ml EDTA Blut)

MLPA Subtelomere (für alle MLPA Untersuchungen insgesamt 2 ml EDTA Blut)

MLPA Mikrodeletions-/Mikroduplikationssyndrome

MLPA X-assoziierte mentale Retardierungssyndrome

Spezifische Fragestellungen

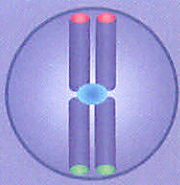
(H: 5 ml Heparinblut; E: 2 ml EDTA Blut)

- | | | |
|---|--|--|
| <ul style="list-style-type: none"><input type="checkbox"/> Achondroplasie E<input type="checkbox"/> Adrenogenitales Sy CYP21A2 HE<input type="checkbox"/> Alagille Sy E<input type="checkbox"/> Angelman HE<input type="checkbox"/> Apert E<input type="checkbox"/> Azoospermie AZF HE<input type="checkbox"/> Beckwith-Wiedemann HE<input type="checkbox"/> Blackfan-Diamond ° RPS19 E<input type="checkbox"/> CATCH 22/di George HE<input type="checkbox"/> Cong. nephrot. Sy E:
° NPHS1; ° NPHS2; ° WT1<input type="checkbox"/> Cornelia de Lange HE<input type="checkbox"/> Cri du Chat HE<input type="checkbox"/> CVID E:
° TNFRSF13B; ° TNFRSF13C<input type="checkbox"/> Cystische Fibrose E<input type="checkbox"/> Denys-Drash-/Frasier E<input type="checkbox"/> Fam. Mittelmeerfieber E<input type="checkbox"/> Fragiles X HE<input type="checkbox"/> Fructoseintoleranz E<input type="checkbox"/> Hämochromatose E<input type="checkbox"/> Hered. Albright Osteodystr. E<input type="checkbox"/> Hered. Pankreatitis E<input type="checkbox"/> Holt-Oram E | <ul style="list-style-type: none"><input type="checkbox"/> Hyperbilirub., Meulengracht E<input type="checkbox"/> Hyperhomocysteinämie E<input type="checkbox"/> Hyper-IgM Immundef, X-chr E<input type="checkbox"/> ICF H<input type="checkbox"/> Kallmann Sy 1 HE<input type="checkbox"/> Kallmann Sy 2 HE<input type="checkbox"/> Laktoseintoleranz E<input type="checkbox"/> Lissenzephalie 1 E:
° DCX; ° PAFAH1B1; ° TUBA1A<input type="checkbox"/> Miller-Dieker HE<input type="checkbox"/> MODY Typ 2 E<input type="checkbox"/> MODY Typ 3 E<input type="checkbox"/> Nijmegen HE<input type="checkbox"/> Noonan HE<input type="checkbox"/> Osteopetrosis E:
° TCIRG1; ° OSTM1; ° CICN7<input type="checkbox"/> Pelizaeus Merzbacher HE<input type="checkbox"/> Period. Fieber (Hyper-IgD) E<input type="checkbox"/> Period. Fieber (Muckle-Wells) E<input type="checkbox"/> Period. Fieber (TRAPS) E<input type="checkbox"/> Persist. Müller-Gang II E<input type="checkbox"/> Pfeiffer Sy E<input type="checkbox"/> Prader Willi HE<input type="checkbox"/> Premature Ovarian Failure E:
° FMR1; ° BMP15 | <ul style="list-style-type: none"><input type="checkbox"/> Prog. myokl. Epilepsie (Unverricht-Lundborg) E<input type="checkbox"/> Pseudohypoaldost. I (MLR) E<input type="checkbox"/> Pseudohypoparathy. I E<input type="checkbox"/> Rett HE<input type="checkbox"/> Rubinstein-Taybi HE<input type="checkbox"/> Silver-Russell HE<input type="checkbox"/> Sotos HE<input type="checkbox"/> Torsionsdystonie, aut. dom. E<input type="checkbox"/> Transthyretin Amyloidose E<input type="checkbox"/> Tumöröse Calcinose E:
° FGF23; ° GALNT3; ° KL<input type="checkbox"/> Wachstumshormoninsensivitätssy E<input type="checkbox"/> WHIM E<input type="checkbox"/> Williams-Beuren HE<input type="checkbox"/> Wiskott Aldrich E<input type="checkbox"/> Wolf-Hirschhorn HE<input type="checkbox"/> X-chr. lymphoprolif. Erkr. (XLP) E
° SH2D1A; ° XIAP<input type="checkbox"/> X-Inaktivierungsmuster E<input type="checkbox"/> Zöliakie E<input type="checkbox"/> Zuckerintoleranz (LCT, ALDOB) E |
|---|--|--|
- Vollständiges Leistungsangebot entnehmen Sie bitte der Preisliste auf www.medgen.at**

Andere Verdachtsdiagnose/Fragestellung:

Bemerkungen/klinische Daten:

Bitte legen Sie die EINVERSTÄNDNISERKLÄRUNG bei und beachten Sie die jeweils gültigen gesetzlichen Versandvorschriften der Post für biologisches Material!



Informed consent for genetic testing

I, DOB confirm that
(Last name, first name)

Mrs / Mr Dr. has informed me about the nature,
(name of referring clinician)

the purpose, the effectiveness, the limitations, the benefits and risks of the planned genetic test.

I consent to have a sample from myself taken for the following genetic testing:

.....

I know that I can withdraw this consent at any time. In that case, I will notify medgen.at in written form.

I know that the remaining sample will be kept at medgen.at GmbH to allow verifiability of the results and to perform additional tests that may perhaps be necessary.

.....
(Place, date)

(Signature of Patient)

(Signature of referring clinician present)

The Austrian "Gentechnikgesetz" §69 states that genetic testing is solely allowed if there is a written statement of the person to be tested which confirms that beforehand the person has been informed by a specialized doctor (human genetics, medical genetics or a specialist for the medical field in question) about the nature, purpose and effectiveness of the test. Based on this information the person consents with his/her free will to the genetic test.