DIAGENOM GMBH
Molecular and cytogenetic diagnostics

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| Patient | |
|---|---|
| Surname, Name | |
| Date of birth | |
| Street<br><br>Town postcode<br>Country | |
| Sex | ○ female ○ male |

| Physician | |
|---|---|
| Name<br><br>Clinic/Institute<br><br>Address<br><br><br><br>Phone- / fax. no. | |

Invoice to: ○ clinic ○ patient ○ other(specify)

Report by fax? ○ yes ○ no

Patient or family member(s) already known to Diagenom: ○ no ○ yes Patient No. .....

Sample date: .....

Follow-up visit: .....

Samples: **Cytogenetics**

○ Heparin blood (10 mL at RT)
○ Bone marrow aspirate in heparin (5 mL at RT)
○ Amniotic fluid (15-20 mL at RT)
○ CVS (10-20 mg in sterile medium at RT)
○ Other (please inquire)
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**Molecular genetics**

○ EDTA blood (3-5 mL at RT)
○ DNA (1-5 µg at RT)
○ Cell culture, e.g. fibroblasts (25 mL, confluent at RT)
○ CVS (10-20 mg in sterile medium at RT)
○ Amniotic fluid (15-20 mL at RT)
○ FFPE tissue block
○ Buccal swab
○ Bone marrow aspirate in heparin (5 mL at RT)

**Sampling for cytogenetic analysis: Monday – Thursday; Friday and Saturday on arrangement. Please ensure delivery within 24h. Please contact us prior to sending prenatal samples for molecular genetic analysis.**

## Requested analysis

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## Clinical symptoms

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## Family tree

## Declaration

I affirm that the submitted patient material was obtained in accordance with relevant national legislation and the results likewise will only be used in accordance with the appropriate regulations. The patient has been offered genetic counseling regarding the implications of the test result and agrees to the performance of the requested analysis.

Location/date:..... Physician's signature:.....