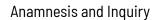
## Order Form Predictive Testing





Patient		Sender / Clinic		
Surname:		Surname:		
First name:		First name:		
Date of birth:		Institution:		
Sex (assigned at birth):	male	Street:		
Gender (if differs from sex assigned at birth):		Postcode/City:		
,	n 🖵 self-described:	Country:		
Material		Phone:		
☐ Blood ml (min. 1-2 ml EDTA-bloo		Email:		
☐ Dried blood spot cards (at least 5 sp		VAT:		
· -	entr. ≥ 50 ng/µl) DNA-No.:	If applicable, please include	de a VAT number or a copy of your b	usiness registration certificate.
Source material of extracted DNA:	(e.g. EDTA blood, skin biopsy)	Invoice	<ul><li>□ to sender / clinic</li><li>□ to patient / other (KVA-</li></ul>	No.:
☐ Other specimen		Surname:		
External ID:		First name:		
Date of sample collection:		Street:		
Samples can be sent by mail in a cardboard bo be exposed to direct sunlight. Dried blood spot	x or air cushion envelope. Samples should not cards can be ordered for free (info@cegat.com).	Postcode/City:		
Declaration of consent		Country:		
	d comprehensive information regarding the genetic well as the possibilities and limitations of molecular withdraw my consent for genetic analyses.	Email:		
be recorded, evaluated or stored in an pseudonyr	nal data and the data obtained in the analysis will nized form in scientific databases, and that further, onfidentiality, the request, or parts thereof, may be	-	these boxes, your answer my genetic material for additional te	
I consent to the re-evaluation of my test results wit become apparent, my Physician will be informed by	thin the data storage period. If significant alterations ye-mail.	I consent to the storage of m	ny test results beyond the timespan	of 10 years
	as requested, the analysis can be expanded to all class 4 and 5) in genes which are related to the screen for differential diagnosis).	(as required by German law).  I consent to the pseudonymound/or test results for scientific	ous storage and use of surplus gene c research and in scientific literature.	☐ Yes ☐ No
I have been informed, and agree to the electronic s collected by CeGaT GmbH.	torage, processing, use, and transmission of all data		ndary findings I would	
For more detailed information on data priv www.cegat.com/privacy-policy.	acy as well as your rights please refer to			☐ Yes ☐ No fit within the scope of the requested
that there is the possibility that the list of genes of added or removed) by the time the sample is analyze	scientific research. It should therefore be recognized in the order form may have changed slightly (genes ted in the laboratory. By signing this form, the patient ay be slightly different from what is currently listed. les are sequenced for each sample.	alterations (ACMG classes action exists for you or you of Medical Genetics and G www.cegat.com/acmg-genes absence of secondary finding	4 and 5) within selected genes, fur family (according to the current tenomics; details on genes and as t). There is no claim of a comprehe gs cannot be used to indicate a reduction	
This declaration of consent can be any time. I have had sufficient time	completely or partially withdrawn at to consider giving my consent.		ested as "additional analy	ling to current recommen- rses".
	ed to request genetic testing for the above-mentioned thorized, and that I have fulfilled the requirements, to the the consent of all legal guardians.		etic Diagnostic Act (GenDG) we wase indicate here the contact email	vill issue the medical report to the I of the counselling physician:
	referring physician, confirm that the patient received esting. The patient's consent has been obtained in	Email:		
writing.		Physician's stamp	) / Barcode	DAKKS  Deutsche Akkreditierungsstelle D-ML-13206-01-00
Patient / Legal Guardian (Block letters)	Physician (Surname, First name)			CAP ACCREDITED COLLEGE of AMERICAN PATHOLOGISTS CLIA CERTIFIED ID: 99D2130225
X Patient / Legal Guardian	X Physician			CeGaT is accredited by DAkkS according to DIN EN ISO 15189:2014,
(Date, Signature)	(Date, Signature)			the College of American Pathologists (CAP) and CLIA.

## Order Form Predictive Testing





For targeted and effective processing, please complete the medical history form with as much detail as possible and include a copy of all existing reports.

	N <sub>O</sub>	Yes	What disease? Diagnosis / symptoms	Age of onset	Relationship to the patient (e.g., mother)
Parkinson					
)ementia					