SYNLAB MVZ
Human Genetics Freiburg GmbH
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Humangenetik Freiburg

A MEMBER OF SYNLAB

DAkkS Deutsche Akkreditierungsstelle D-ML-21093-01-00

REQUISITION FORM FOR CADASIL TESTING

Health Insurance: *Patient information*
NAME:
Forename:
DOB:
Address:

Billing information: insured/S2-form ☐
private/self-payer ☐

Report should be send to:
sender ☐
responsible physician ☐

Patient information (prenatal diagnostic and urgent diagnostics: please contact us beforehand)
gender:
☐ male
☐ female

Is the patient currently **pregnant**?
☐ yes week:_____
☐ no

Material: ☐ DNA ☐ EDTA-blood: from date/time_____ ☐_____

Indication and additional clinical information: (Clinical findings, previous results etc.)

Information about the family/family tree:

Genetic Testing:

☐ **Gene panel** cerebral microangiopathy*:* ***NOTCH3, HTRA1, COL4A1, COL4A2, GLA***

- **Analysis of the genes**: ☐ ***NOTCH3*** (CADASIL)
  ☐ ***HTRA1*** (CARASIL) ☐ ***COL4A1*** (Porencephalie, stroke (early))
  ☐ ***GLA*** (Morbus Fabry) ☐ ***COL4A2*** (Porencephalie, stroke (early))

☐ **analysis of**: gene: _____ Mutation: _____ ☐ only *NOTCH3* hotspots

We are cooperating with the institute for stroke and dementia research (LMU; university clinic munich, germany) (Prof. Dr. M. Dichgans) CADASIL-Hotline: +49-89-4400-46220.

Stamp or/and contact information of the clinician

_____**X**_____ _____
City, Date Signature, Doctor print name

Sample requirements. 5-10 ml EDTA-blood or DNA; Send safely packed by normal or courier. Delivery: max. 5 days

Please, send the sample(s), requisition- and consent form to:
SYNLAB MVZ Human Genetics; Heinrich-von-Stephan-Str. 5 D-79100 Freiburg, Germany

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INFORMED CONSENT FOR GENETIC TESTING

(According to the German gene diagnostics act, GenDG**)**

Patient: _____ _____-_____-_____
NAME, Forename *DOB*

Clinical diagnosis/Analysis of gene(s):

_____

Please select:

This testing is for carrier status or prenatal testing (predictive testing)? yes ☐ no ☐

If yes, has genetic counselling been performed? yes ☐ no ☐

Please inform me of all incidental findings that to our present knowledge have a health impact for me or my family: yes ☐ no ☐

With my signature I confirm that:

- I have been informed about the possibilities of prevention and treatment, as well as the aims, type, extent and limits of the planned genetic investigation.
- I have been informed about the inherent risks of taking blood or tissue samples.
- I was provided sufficient time to consider, before giving my consent to the above investigation.
- I have been informed that I may retract my consent at any stage.

I agree that (**Please delete as appropriate)**

- my test results may be used for scientific purposes. The data will be treated conform to the legal provisions of data protection (anonymization, resp. pseudonymization).
- my sample(s) can be stored and used for quality control and scientific purposes (for this my data will be made completely anonymous) and further requests by your clinician (transfer of ownership according to §950 BGB).
- Some genetic tests may be performed at an accredited cooperating laboratory (only if required).
- my test results can be stored beyond the time span of 10 years (as required by the German diagnostic act).

_____ **X** _____ **X** _____
City, Date Signature **Patient (resp. legal guardian)** Signature **Doctor** (and print)

Important: We require all the documents required by the legislation of your country for genetic testing. The german diagnostic act asks for an informed consent.

Please, send the sample(s), requisition- and consent form to:
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