Patient Family Name
Patient First Name
Patient Date of Birth
Patient Sex: female ☐ male ☐ diverse ☐

BIOSCIENTIA INTERNATIONAL

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Patient ID (Barcode)

Client/physician ID and Signature

Declaration of Informed Consent for Genetic Examinations

With my signature I declare that I was briefed by my physician: _____ about the nature, importance and implications of the genetic test. With my signature I declare my agreement for the blood/tissue collection and the processing of the following genetic examinations:

☐ Factor II/Prothrombin	☐ Factor V-Leiden	☐ Hemochromatosis/HFE
☐ APOE	☐ CYP2C19	☐ LCT (Lactose Intolerance)
☐ HLA-B27	☐ HLA-B51	☐ HLA-DQ2/8 (celiac disease)
☐ HLA Typing	☐ Other (Please specify):	

(Please tick as appropriate)

I have been informed that the recorded data are stored in paper form and/or in electronic form according to legal requirements. I understand that once results have been reported they are subject to the 10-year retention period and cannot be destroyed before their expiry even if requested by the investigated person.

I agree that my data will be passed on to a medical clearing house for billing purposes. If necessary, the investigation order can be forwarded to a specialized cooperating laboratory.

I am aware that I may withdraw this consent at any time, verbally or in writing, without giving reasons and without this having any adverse consequences for me.

I consent to the communication of the test results to other attending physicians in the practice/facility or substituting physicians, if my informing physician is not available.

Name of patient or legal guardian (in block letters): _____

Place and Date: _____ Signature of patient or legal guardian: _____

Alternatively for the attending physician:

I have a declaration of consent including all above-mentioned subitems.

Place and Date: _____ Signature of attending physician: _____