Request form for genetic testing of thrombophilic mutations

Personal data of the patient (label):	**Referring physician:**
Name and surname: Insurance number: Date of birth: Insurance: ☐ self-payer Sex: ☐ man ☐ woman Address: Diagnosis (MKN):	*(name, specialisation, identification number, workplace, stamp, signature)*

Primary sample:	**Other material:**
☐ peripheral blood *(5 ml non-coagulated in K_3EDTA)*	☐ DNA isolated from:

Date and time of collection:	**Date and time of indication** (if different from the collection date):

Clinical data: (to be completed by the referring physician) ☐ **STATIM**

Requested tests:

☐ Leiden (G1691A) *F5*	☐ C677T *MTHFR*	☐ polymorfismus 4G/5G *PAI-1*
☐ G20210A *F2* (protrombin)	☐ A1298C *MTHFR*	☐ Haplotyp M2 genu *ANXA 5*

Informed consent* – examined person:

AGREES ☑ with the examination of the sample
☐ with the use of the sample for research
☐ with sample storage

DISAGREES ☐ with sample storage

*) By submitting the request, the referring physician confirms that the patient or legal representative has signed the Informed Consent, which is either stored in the patient's documentation or attached to this request.

Examination conducted by: GENNET, Ltd., GENNET Laboratories, Pekařská 635/6, 158 00 Praha 5 - Jinonice, Tel: 226 231 691

Laboratory records:
Date and time of sample/request reception:
Sample/request accepted by: