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 V-Leiden mutation	☐ Hemochromatosis/HFE	☐ Factor II/Prothrombin
☐ 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.

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: _____