Health insurance fund or cost carrier

Surname, first name and address of insured

Date of birth

Health insurance No. | Insured No. | Status

Establishment No. | Doctor No. | Date

Responsible practice/doctor (stamp)

WM-3212-EN-001

SEPA direct debit mandate reference:

Attach or enter barcode

Send the original and blood sample in the return box.

Singleton pregnancy

PraenaGenom (NIPS)

Order for genetic testing

Selection required

☒ **Examination for trisomies 21/18/13**

Cost carrier

☐ **The analysis of trisomies 21/18/13 is covered by health insurance fund.** Laborüberweisungsschein Muster 10 must be enclosed.

☐ **The analysis of trisomies 21/18/13 is carried out as IGeL.** The patient chooses the analysis as a self-payer. **169,03 Euro**

Select an option (Self-payer)
Min. gestational week 10 + 1 p.m.

☐ **SCA, RAA, CNV, Determination of sex and 3 microdeletions** **+ 221,50 Euro**
Examination of whole-chromosome misdistribution (monosomies and trisomies) of the autosomes, for misdistribution of the sex chromosomes (Turner syndrome, Klinefelter syndrome, Triple-X syndrome, XYY syndrome), for partial deletions and duplications ≥ 7 Mb of the autosomes, and for microdeletions < 7 Mb: DiGeorge syndrome (microdeletion 22q11.2); Prader-Willi syndrome (15q11, deletions of the paternal allele); Angelman syndrome (15q11, deletions of the maternal allele).

☐ **SCA, RAA, CNV, Determination of sex and 9 microdeletions** **+ 291,46 Euro**
Examination of whole-chromosome misdistribution (monosomies and trisomies) of the autosomes, for misdistribution of the sex chromosomes (Turner syndrome, Klinefelter syndrome, Triple-X syndrome, XYY syndrome), for partial deletions and duplications ≥ 7 Mb of the autosomes, and for microdeletions < 7 Mb: DiGeorge syndrome (microdeletion 22q11.2); Cri-du-chat syndrome (5p deletions); Prader-Willi syndrome (15q11, deletions of the paternal allele); Angelman syndrome (15q11, deletions of the maternal allele); 1p36 deletion syndrome; Wolf-Hirschhorn syndrome (4p deletions); Jacobsen syndrome (distal 11q deletion syndrome); Langer-Giedion syndrome (microdeletion 8q23.3-q24.11); Smith-Magenis syndrome (microdeletion 17p11.2).

To be completed by the doctor

Date of blood draw DD/MM/YYYY

☐ **Repeat (new blood sample)**

☒ **Singleton pregnancy**

Gestational week + p.m.

☐ **Vanishing twin**

Clinical information about pregnancy

Height cm

Current weight kg

Notification of sex ☐ Yes ☐ only in gestational week 14 + 0 p.m. ☐ No

Requirement according to GenDG

I have provided the above-mentioned patient with human genetic counselling and information in accordance with the GenDG. The patient has given her written consent for the selected genetic examination.

Name of the responsible doctor

Fax No. for result notifications

Email address of the responsible doctor

Place, Date | **Signature of the responsible doctor** ✗

To be completed by the patient

Consent to the genetic examination and to the use of data

With my signature, I give my consent to the above genetic examination. I have received human genetic counselling and information from my responsible doctor in accordance with the GenDG. **I consent to the processing of my personal data by Eurofins Humangenetik und Pränatal-Medizin MVZ GmbH, Friedenheimer Brücke 19, Friends Tower I, 80639 München, as well as (pseudonymized) by the partner laboratory Eurofins Genoma, Via Enrico Cialdini 16, Affori-Centre, 20161 Milan, Italy, to assist with the analysis of the laboratory results.** I can revoke my consent to my responsible doctor at any time. In the event of revocation, the processing of my personal data that has taken place up to that point remains lawful. The privacy policy according to § 13, 14 GDPR can be viewed at https://de.praenatal-medizin.de/datenschutzerklaerung.

The patient consents to the storage and use of surplus examination material that is not identified by name for purposes of quality assurance, scientific research as well as the development of new diagnostic options. ☐ **Yes** ☐ **No**

Telephone number of the patient

Email address of the patient

Place, Date | **Signature of the patient** ✗

Privately insured / self-payer

Agreement for IGeL for privately insured & self-payer

I would like to make use of the genetic examination(s) as an IGeL service(s), which is/are not part of the SHI-accredited medical care, as a self-payer/private patient via my responsible doctor. This request is not at the initiative of my doctor. I will pay for the examination myself.

SEPA Direct Debit Mandate – Creditor ID: DE 71ZZZ00002550373: I hereby authorise Eurofins Humangenetik und Pränatal-Medizin MVZ GmbH to collect the payment to be made by me in accordance with the selected genetic examination(s) after separate notification of the results to the responsible doctor in each case. If my address is available, I will receive the invoice/s after receipt of payment. Even in the event of a revocation, I must pay for the service provided. No German bank account? Please transfer the total amount in advance to Eurofins Human Genetics and Prenatal Medicine MVZ GmbH, IBAN DE54 2073 0017 7000 0063 00, Swift-BIC HYVEDEMME17, UniCredit (HypoVereinsbank).

First name of the account holder

Surname of the account holder

IBAN D E

Place, Date | **Signature of the authorised representative/the patient** ✗