PHARMACOGENOMICS

DIAGNOSTIC TESTING

ORDER FORM

BARCODE

HEALTH CARE PROVIDER INFORMATION

INSTITUTION/PRACTICE	ADDRESS (STREET NAME, NO., CITY, POSTCODE, COUNTRY)
FIRST NAME	TELEPHONE NUMBER (COUNTRY CODE & NUMBER)
LAST NAME	E-MAIL ADDRESS (FOR REPORT ACCESS)

PATIENT INFORMATION

FIRST NAME	ADDRESS (STREET NAME, NO., CITY, POSTCODE, COUNTRY)
LAST NAME	TELEPHONE NUMBER (COUNTRY CODE & NUMBER)
DATE OF BIRTH (DD/MM/YYYY)	IDENTIFICATION NO. (IF APPLICABLE)

GENETIC SEX ☐ FEMALE ☐ MALE
☐ OTHER (SPECIFY KARYOTYPE IF KNOWN):

DECLARATION OF CONSENT IN ACCORDANCE WITH THE GERMAN GENETIC DIAGNOSTICS ACT (GenDG)

I confirm that I consent to the collection and analysis of the necessary genetic sample, and that I have been fully informed in accordance with Section 9 of the German Genetic Diagnostics Act (GenDG), regarding, but not limited to, the following:

- the purpose, nature, scope, and significance of the genetic test,
- the results that may be obtained,
- the intended use of the genetic sample and the test results,
- my right to withdraw my consent with effect for the future, as well as my right not to know and my right to request destruction of the test result, or parts thereof.

In rare cases, incidental findings may be identified that do not correspond to the test request but are clinically relevant (procedure in accordance with ACMG recommendations).

I would like to be informed about these genetic findings.
☐ Yes ☐ No

After the analysis is completed, I allow the use of the genetic sample and the genetic data generated from it, after removal of any personal data, for:

- quality assurance measures
☐ Yes ☐ No
- publications / conference presentations
☐ Yes ☐ No

No selection will be regarded as "No."

If I withdraw my consent before receiving the results, I agree to cover the costs incurred by the laboratory up to that point.

I acknowledge that the sample(s) and results may be stored for an extended period at my request. Should this be relevant now or in the future (e.g., in the case of irreplaceable material), I will enter into a separate agreement with the laboratory.

PLACE, DATE	NAME (BLOCK LETTERS)	**X** SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

According to the GenDG, predictive diagnostics may only be ordered by medical specialists in human genetics or, depending on the specific field, by appropriately qualified specialists in that field. I hereby confirm, as the treating physician, that I possess the necessary qualifications. I understand that specialists in human genetics are available to communicate the results of incidental findings that fall outside my area of expertise.

PLACE, DATE	NAME OF RESPONSIBLE MEDICAL PROFESSIONAL (BLOCK LETTERS)	**X** SIGNATURE OF RESPONSIBLE MEDICAL PROFESSIONAL

PLEASE NOTE: If the patient did not sign this order form: I, the responsible medical professional, confirm that the patient received genetic counselling and agrees with the genetic testing. The patient's consent has been obtained in writing.

X SIGNATURE OF RESPONSIBLE MEDICAL PROFESSIONAL

MEDICOVER GENETICS

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www.medicover-genetics.com

PGx-DGNS-OF-V3-10/26

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CLINICAL INFORMATION

Body weight: _____ kg Height: _____ cm Body surface area: _____ m²

History of drug intolerance or lack of efficacy:

Unusual observations during medication use? ☐ Yes ☐ No if yes, elaborate _____

Signs of overdose? ☐ Yes ☐ No if yes, elaborate _____

Low or absent therapeutic effect? ☐ Yes ☐ No

Medication history:

Please list current and recent medications or attach a medication list if available.

1. Name: _____ Dose: _____ Time period: _____
   Therapeutic level: ☐ Elevated ☐ Normal ☐ Too low ☐ Not measured
2. Name: _____ Dose: _____ Time period: _____
   Therapeutic level: ☐ Elevated ☐ Normal ☐ Too low ☐ Not measured
3. Name: _____ Dose: _____ Time period: _____
   Therapeutic level: ☐ Elevated ☐ Normal ☐ Too low ☐ Not measured
4. Name: _____ Dose: _____ Time period: _____
   Therapeutic level: ☐ Elevated ☐ Normal ☐ Too low ☐ Not measured

SAMPLE MATERIAL

Collection date: _____

Time: _____

☐ EDTA blood (2-5 mL)

☐ DNA from _____ (≥ 250 ng; ≥ 100 ng/µL)

☐ Buccal swab

☐ Other (specify): _____
(Prior approval is required, please contact us in advance for more information)

OUR TESTS

PGx PANELS BY CLINICAL AREA

☐ **00549 PGx anaesthesia and pain**
BCHE, CYP2B6, CYP2C9, CYP2D6, CACNA1S, RYR1

☐ **00821 PGx cardiovascular**
CYP2D6, CYP2C9, CYP4F2, VKORC1, CYP2C19, ABCG2, SLCO1B1

☐ **00551 PGx CYP450 drug response**
CYP1A2, CYP2B6, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP2A6, CYP2C8, CYP4F2

☐ **00028 PGx malignant hyperthermia**
CACNA1S, RYR1

☐ **00820 PGx metabolic syndrome**
CYP2C19, CYP2C9, CYP2D6, ABCG2, SLCO1B1

☐ **00546 PGx neurology and psychiatry**
ABCB1, COMT, CYP2B6, CYP2C9, CYP2D6, CYP2C19, CYP3A5, CYP1A2, CYP3A4

☐ **00545 PGx oncology**
CYP2C8, CYP2D6, DPYD, NUDT15, TPMT, UGT1A1

☐ **00472 PGx statin**
SLCO1B1, ABCG2

PGx ONCOLOGY TESTS

☐ **00474 PGx azathioprine**
NUDT15, TPMT

☐ **00461 PGx 5-fluorouracil**
DPYD

☐ **00478 PGx irinotecan**
UGT1A1

☐ **00550 PGx paclitaxel**
CYP2C8

☐ **00473 PGx tamoxifen**
CYP2D6

☐ **00639 PGx tebentafusp**
*HLA-A*02:01*

PGx MANDATORY TESTS

☐ **00562 PGx abacavir**
*HLA-B*57:01*

☐ **00563 PGx carbamazepine**
*HLA-B*15:02*

☐ **00627 PGx cystic fibrosis**
CFTR

☐ **00862 PGx donanemab**
APOE

☐ **00475 PGx eliglustat**
CYP2D6

☐ **00461 PGx 5-fluorouracil**
DPYD

☐ **00478 PGx irinotecan**
UGT1A1

☐ **00629 PGx lecanemab**
APOE

☐ **00479 PGx mavacamten**
CYP2C19

☐ **00630 PGx migalastat**
GLA

☐ **00471 PGx siponimod**
CYP2C9

☐ **00639 PGx tebentafusp**
*HLA-A*02:01*

For further information on specific tests and/or gene content as well as our Privacy Policy, please visit our website: www.medicover-genetics.com.
If you have additional questions or concerns, please contact us at info.genetics@medicover.com

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