PHARMACOGENOMICS

PREVENTIVE 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):

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)

TEST INFORMATION

The **PGx preventive panel** is a broad, preemptive screening test designed for proactive medication planning. It supports safer, more personalised prescribing by identifying inherited genetic variants that may affect drug metabolism, transport, and pharmacodynamic response across multiple therapeutic areas.

This panel is **not a diagnostic test**. Results are generated and interpreted through an automated bioinformatic pipeline. Phenotype assignments and dosing annotations are provided automatically and are not subject to individual medical review or validation. The results are intended for informational purposes only and must not be used as the sole basis for medical or prescribing decisions.

For gene content and further information, please visit www.medicover-genetics.com or contact us at info.genetics@medicover.com.

PHYSICIAN'S CONFIRMATION

I confirm that informed consent has been obtained from the patient (or legal guardian) for this preventive pharmacogenomic test. The patient has received sufficient information about the test, had the opportunity to ask questions, and was given adequate time to make an informed decision. I am authorised to request this test and confirm that appropriate counselling has been provided.

Name of the ordering physician

FIRST NAME _____ LAST NAME _____

SIGNATURE OF THE ORDERING PHYSICIAN

DATE OF SIGNATURE

MEDICOVER GENETICS

MVZ Martinsried GmbH
Lochhamer Str.29, 82152 Martinsried, Germany
www.medicover-genetics.com

PGx-PREV-OF-V2-10/26

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PATIENT DECLARATION OF CONSENT

Please read this declaration carefully.

By signing this form, I confirm that I:

- ☐ Have been informed about the purpose, scope, and limitations of this pharmacogenomic test.
- ☐ Consent to the collection and analysis of my sample for the purpose of pharmacogenomic testing.
- ☐ Consent to the processing of my personal and genetic data in accordance with EU's General Data Protection Regulation (GDPR), Germany's Genetic Diagnostics Act (GenDG — Gendiagnostikgesetz), and EU's In Vitro Diagnostic Medical Devices Regulation (IVDR).
- ☐ Understand that I may withdraw my consent at any time without giving a reason, and request deletion of my data.
- ☐ Understand that I will only be charged for costs incurred up to the point of withdrawal.
- ☐ Understand that I may choose not to receive the results (right not to know).
- ☐ Acknowledge that this test analyses only selected pharmacogenes and does not provide information about other diseases.
- ☐ Have had the opportunity to ask questions and receive clear answers.

Additional consents and information. By signing this form, I confirm that I:

YES	NO	
☐	☐	Consent to the storage of my sample and results beyond the statutory minimum period (10 years), and to the use of pseudonymised material for quality assurance or scientific purposes (no claim to long-term storage).
☐	☐	Allow the test order form or parts of it to be shared with collaborating laboratories if needed.
☐	☐	Consent to the pseudonymised use of surplus sample and/or data for scientific research.

In addition:

☐ consent to sharing a copy of my test results with the following physician or healthcare provider, in line with my explicit request and the internal procedures of _____ (legal entity name).

PHYSICIAN NAME

POSTCODE/CITY

STREET

COUNTRY

Completed by: ☐ Patient ☐ Parent/Legal Guardian

FIRST NAME

LAST NAME

SIGNATURE OF PATIENT/LEGAL GUARDIAN

DATE OF SIGNATURE

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INFORMATION FOR PATIENTS

IMPORTANT DISCLAIMERS

The following disclaimers provide important background information about the PGx preventive panel. Patients (or legal guardians) are encouraged to read them before signing the consent form, and physicians or healthcare professionals should be familiar with them as part of the test ordering process.

Scope & Purpose
This pharmacogenomic test is designed for preemptive screening and preventive use. It provides insights into drug metabolism based on genetic variation. It is not a diagnostic test and must not be used to detect, confirm, or treat disease.

Medical Disclaimer
The results do not constitute medical advice. They do not replace a clinical evaluation. All findings must be interpreted by a qualified healthcare professional.

Regulatory Compliance
This test is conducted in accordance with the German Genetic Diagnostics Act (GenDG), In Vitro Diagnostic Medical Devices Regulation (IVDR), and General Data Protection Regulation (GDPR). It is performed in an ISO 15189-accredited laboratory.

Physician Consultation
This test does not replace medical advice, diagnosis, or treatment. Results must not be used to change, start, or stop any medication without consultation with a qualified physician or healthcare professional.

Limitations
This test analyses a selected set of clinically validated pharmacogenes. It does not cover all genetic variants or gene–drug interactions. Environmental, lifestyle, or comorbid factors are not assessed.

Data Protection & Usage
All data is processed in accordance with GDPR. Patients may request data deletion at any time.

Right Not to Know
As per GenDG, patients may opt not to receive their test results and may withdraw consent at any time.

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