WHOLE EXOME SEQUENCING

BARCODE

ORDER FORM

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

DUO / TRIO WES DECLARATION OF CONSENT

For Duo or Trio WES requests, please refer to the Declaration of Consent on pages 5 and 6. The consent must be read, completed and signed by the relevant parent(s) or family member(s) included in the analysis.

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

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CLINICAL INDICATION

IMPORTANT: *Please provide as much detail as possible on the patient's clinical symptoms and relevant family history. This information supports informatics filtering and accurate variant interpretation. Please complete the phenotypic features as fully as possible using the* ***HPO term list (Human Phenotype Ontology) on pages 3 and 4****, and add any relevant individual details where appropriate.*

Is there a pregnancy / partner's pregnancy? ☐ No ☐ Yes Gestational week _____ + _____

Family history

Other affected family members with similar symptoms? ☐ No ☐ Yes ☐ Unknown

If yes, relationship(s): _____

Parental consanguinity: ☐ Yes ☐ No ☐ Unknown

Previous genetic testing in the patient and/or family? ☐ Yes ☐ No ☐ Unknown *If yes, attach report / add details under clinical symptoms*

☐ Further clinical information attached

PARENTAL INFORMATION FOR DUO / TRIO WES

For Duo/Trio WES, please ensure that complete identifying and sample information is provided for each biological parent included in the analysis.

Mother

First name / Last name: _____

Date of birth: _____

Father

First name / Last name: _____

Date of birth: _____

TEST REQUEST

☐ Single WES *(only the index patient)*

☐ Duo WES *(Patient and one biological parent)*

☐ Trio WES *(Patient and the two biological parents)*

For analyses beyond Trio WES, please contact us in advance.

SAMPLE MATERIAL

Index patient

Collection date: _____

Time: _____

☐ EDTA blood (2-5 mL)

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

☐ Other (specify): _____

If Duo- or Trio WES testing is requested, please also complete the following:

Parent / family member 1

Collection date: _____

Time: _____

☐ EDTA blood (2-5 mL)

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

☐ Other (specify): _____

Parent / family member 2

Collection date: _____

Time: _____

☐ EDTA blood (2-5 mL)

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

☐ Other (specify): _____

For other sample types, prior approval is required. Please contact us in advance for more information.

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CLINICAL PHENOTYPE INFORMATION (HPO TERMS)

Please indicate the patient's phenotypic features as completely as possible using the HPO term list below. Accurate phenotype information supports bioinformatic filtering and variant interpretation. Please add any relevant individual details where needed.

PRENATAL MEDICAL HISTORY

- ☐ Not examined / unknown
- ☐ No relevant abnormalities
- ☐ Premature birth (HP:0001622)
- ☐ Intrauterine growth retardation (IUGR, HP:0001511)
- ☐ Polyhydramnios (HP:0001561)
- ☐ Oligohydramnios (HP:0001562)
- ☐ Decreased fetal movement (HP:0001558)
- ☐ Intracranial haemorrhage (HP:0002170)
- ☐ Others: _____

DEVELOPMENTAL DELAY / INTELLECTUAL DISABILITY

- ☐ Not examined / unknown
- ☐ No developmental abnormalities
- ☐ No intellectual disability
- ☐ Intellectual disability ☐ mild, ☐ moderate, ☐ severe (HP:0001256, HP:0002342, HP:0010864)
- ☐ Global developmental delay ☐ mild, ☐ moderate, ☐ severe (HP:0001263, HP:0011343, HP:0011344)
- ☐ Motor delay (HP:0001270)
- ☐ Delayed speech and language development (HP:0000750)
- ☐ Autism (HP:0000717)
- ☐ Developmental regression (HP:0002376)
- ☐ Others: _____

CRANIOFACIAL ABNORMALITIES

- ☐ Not examined / unknown
- ☐ No craniofacial abnormalities
- ☐ Macrocephaly (HP:0000256)
- ☐ Microcephaly (HP:0000252)
- ☐ Craniosynostosis (HP:0001363)
- ☐ Broad forehead / Prominent forehead (HP:0000337 / HP:0011220)
- ☐ Oral cleft (HP:0000202)
- ☐ Hypertelorism (HP:0000316)
- ☐ Hypotelorism (HP:0000601)
- ☐ Abnormality of the nose (HP:0000366): _____
- ☐ Abnormality of the outer ear (HP:0000356): _____
- ☐ Micrognathia (HP:0000347)
- ☐ Oligodontia (HP:0000677)
- ☐ Others: _____

BRAIN ABNORMALITIES

- ☐ Not examined / unknown
- ☐ Normal brain MRI
- ☐ Aplasia/Hypoplasia of the corpus callosum (HP:0007370)
- ☐ Agenesis of corpus callosum (HP:0001274)
- ☐ Aplasia/Hypoplasia of the cerebellum (HP:0007360)
- ☐ Aplasia/Hypoplasia of the cerebellar vermis (HP:0006817)
- ☐ Abnormal myelination (HP:0012447)
- ☐ Lissencephaly (HP:0001339)
- ☐ Schizencephaly (HP:0010636)
- ☐ Porencephalic cyst (HP:0002132)
- ☐ Pachygyria (HP:0001302)
- ☐ Polymicrogyria (HP:0002126)
- ☐ Grey matter heterotopia (HP:0002282)
- ☐ Abnormality of the basal ganglia (HP:0002134)
- ☐ Leukoencephalopathy (HP:0002352)
- ☐ Brain atrophy (HP:0012444)
- ☐ Ventriculomegaly (HP:0002119)
- ☐ Hydrocephalus (HP:0000238)
- ☐ Holoprosencephaly (HP:0001360)
- ☐ Others: _____

RESPIRATORY DIFFICULTIES AND RESPIRATORY SYMPTOMS

- ☐ Not examined / unknown
- ☐ No respiratory abnormalities
- ☐ Respiratory insufficiency (HP:0002093)
- ☐ Respiratory failure (HP:0002878)
- ☐ Recurrent infections (HP:0002719)
- ☐ Bronchiectasis (HP:0002110)
- ☐ Others: _____

NEUROLOGICAL SYMPTOMS

- ☐ Not examined / unknown
- ☐ No neurological symptoms
- ☐ Seizures (☐ generalised / ☐ focal)
- ☐ Encephalopathy (HP:0001298)
- ☐ Decreased nerve conduction velocity (HP:0000762)
- ☐ Neuropathy (☐ motor / ☐ sensory)
- ☐ Ataxia (HP:0001251)
- ☐ Tremor (HP:0001337)
- ☐ Dystonia (HP:0001332)
- ☐ Chorea (HP:0002072)
- ☐ Spasticity (HP:0001257)
- ☐ Gait disturbance (HP:0001288)
- ☐ Nystagmus (HP:0000639)
- ☐ Migraine (HP:0002076)
- ☐ Sleep disturbance (HP:0002360)
- ☐ Others: _____

EYE ABNORMALITIES

- ☐ Not examined / unknown
- ☐ No eye abnormalities
- ☐ Abnormality of vision (HP:0000504): _____
  - ☐ Bilateral
- ☐ Retinopathy (HP:0000488)
- ☐ Anophthalmia (HP:0000528)
  - ☐ Bilateral
- ☐ Bilateral microphthalmos (HP:0007633)
- ☐ Strabismus (HP:0000486)
  - ☐ Bilateral
- ☐ Developmental cataract (HP:0000519)
- ☐ Others: _____

HEARING AND BALANCE ABNORMALITIES

- ☐ Not examined / unknown
- ☐ No hearing abnormalities
- ☐ No balance abnormalities
- ☐ Sensorineural hearing impairment (HP:0000407) ☐ Bilateral
- ☐ Conductive hearing impairment (HP:0000405)
- ☐ Vestibular dysfunction: (HP:0001751)
- ☐ Others: _____

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CLINICAL PHENOTYPE INFORMATION (HPO TERMS)

MUSCULOSKELETAL DISORDERS

- ☐ Not examined / unknown
- ☐ No muscular abnormalities
- ☐ No skeletal abnormalities
- ☐ Hypotonia (HP:0001252)
- ☐ Hypertonia (HP:0001276)
- ☐ Elevated circulating creatine kinase concentration (HP:0003236)
- ☐ Ptosis (HP:0000508)
- ☐ Distal arthrogryposis (HP:0005684)
- ☐ Arthrogryposis multiplex congenita (HP:0002804)
- ☐ Short stature (HP:0004322)
- ☐ Skeletal dysplasia (HP:0002652)
- ☐ Tall stature (HP:0000098)
- ☐ Joint hypermobility (HP:0001382)
- ☐ Hand polydactyly / ☐ Foot polydactyly (HP:0001161/HP:0001829)
- ☐ Hand syndactyly / ☐ Foot syndactyly, specify:_____
- ☐ Camptodactyly of finger (HP:0100490)
- ☐ Talipes (HP:0001883)
- ☐ Scoliosis (HP:0002650)
- ☐ Pectus carinatum (HP:0000768)
- ☐ Increased bone mineral density (HP:0011001)
- ☐ Osteoporosis (HP:0000939)
- ☐ Delayed skeletal maturation (HP:0002750)
- ☐ Multiple exostoses (HP:0002762)
- ☐ Others:_____

CARDIOVASCULAR ABNORMALITIES

- ☐ Not examined / unknown
- ☐ No cardiovascular abnormalities
- ☐ Atrial septal defect (HP:0001631)
- ☐ Ventricular septal defect (HP:0001629)
- ☐ Pulmonary stenosis (HP:0001642)
- ☐ Heart defect:_____
- ☐ Cardiomyopathy:_____
- ☐ Hypertrophic cardiomyopathy (HP:0001639)
- ☐ Dilated cardiomyopathy (HP:0001644)
- ☐ Arrhythmia (HP:0011675)
- ☐ Aortic aneurysm (HP:0004942)
- ☐ Abnormality of the vasculature (HP:0002597)
- ☐ Pulmonary arterial hypertension (HP:0002092)
- ☐ Aborted sudden cardiac death (HP:0031628)
- ☐ Others:_____

IMMUNOLOGICAL AND HAEMATOLOGICAL ABNORMALITIES

- ☐ Not examined / unknown
- ☐ No immunological abnormalities
- ☐ No haematological abnormalities
- ☐ Abnormal inflammatory response (HP:0012647)
- ☐ Immunodeficiency (HP:0002721)
- ☐ Recurrent infections (HP:0002719)
- ☐ Anaemia (HP:0001903):
- ☐ Neutropenia (HP:0001875)
- ☐ Thrombocytopenia (HP:0001873)
- ☐ Abnormality of coagulation (HP:0001928)
- ☐ Abnormal circulating enzyme concentration HP:0011021)
- ☐ Others:_____

METABOLIC AND ENDOCRINE ABNORMALITIES

- ☐ Not examined / unknown
- ☐ No metabolic abnormalities
- ☐ No endocrine abnormalities
- ☐ Failure to thrive (HP:0001508)
- ☐ Hemihypertrophy (HP:0001528)
- ☐ Obesity (HP:0001513)
- ☐ Abnormality of the mitochondrion (HP:0012103)
- ☐ Lactic acidosis (HP:0003128)
- ☐ Proteinuria (HP:0000093)
- ☐ Hyperglycaemia (HP:0003074)
- ☐ Hypoglycaemia (HP:0001943)
- ☐ Ketosis (HP:0001946)
- ☐ Diabetes mellitus (HP:0000819)
- ☐ Nephrogenic diabetes insipidus (HP:0009806)
- ☐ Hypothyroidism (HP:0000821)
- ☐ Hypercalcaemia (HP:0003072)
- ☐ Hypoparathyroidism (HP:0000829)
- ☐ Exocrine pancreatic insufficiency (HP:0001738)
- ☐ Hypogonadism (HP:0000135)
- ☐ Others:_____

SKIN, NAIL AND HAIR ABNORMALITIES

- ☐ Not examined / unknown
- ☐ No abnormalities of the skin, nails and hair
- ☐ Multiple cafe-au-lait spots (HP:0007565)
- ☐ Nevus (HP:0003764)
- ☐ Albinism (HP:0001022)
- ☐ Hypopigmentation of the skin (HP:0001010)
- ☐ Hyperpigmentation of the skin (HP:0000953)
- ☐ Eczema (HP:0000964)
- ☐ Ichthyosis (HP:0008064)
- ☐ Nail dysplasia (HP:0002164)
- ☐ Anhidrosis (HP:0000970)
- ☐ Hyperhidrosis (HP:0000975)
- ☐ Alopecia (HP:0001596)
- ☐ Hypertrichosis (HP:0000998)
- ☐ Others:_____

ABNORMALITIES OF THE KIDNEY AND UROGENITAL TRACT

- ☐ Not examined / unknown
- ☐ No renal abnormalities
- ☐ No urogenital abnormalities
- ☐ Not examined / unknown
- ☐ Renal agenesis (HP:0000104)
- ☐ Renal dysplasia (HP:0000110)
- ☐ Renal cyst (HP:0000107)
- ☐ Haematuria (HP:0000790)
- ☐ Proteinuria (HP:0000093)
- ☐ Hypospadias (HP:0000047)
- ☐ Cryptorchidism (HP:0000028)
- ☐ Ambiguous genitalia (HP:0000062)
- ☐ Others:_____

OTHER RELEVANT ABNORMALITIES

If you have additional questions or concerns, please contact us at info.genetics@medicover.com

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ADDITIONAL DECLARATION OF CONSENT FOR DUO / TRIO WES – PARENT / FAMILY MEMBER 1

FIRST NAME:_____ LAST NAME:_____

DATE OF BIRTH (DD/MM/YYYY):_____ IDENTIFICATION NO. (IF APPLICABLE):_____

GENETIC SEX ☐ FEMALE ☐ MALE

☐ OTHER (SPECIFY KARYOTYPE IF KNOWN):_____

Relationship to the patient

☐ Father ☐ Mother ☐ Other, please state relationship:_____

Does the family member have same or similar symptoms as the index patient?

☐ No ☐ Yes, symptoms are:_____

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

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WHOLE EXOME SEQUENCING

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ADDITIONAL DECLARATION OF CONSENT FOR DUO / TRIO WES – PARENT / FAMILY MEMBER 2

FIRST NAME:_____ LAST NAME:_____

DATE OF BIRTH (DD/MM/YYYY):_____ IDENTIFICATION NO. (IF APPLICABLE):_____

GENETIC SEX ☐ FEMALE ☐ MALE

☐ OTHER (SPECIFY KARYOTYPE IF KNOWN):_____

Relationship to the patient

☐ Father ☐ Mother ☐ Other, please state relationship:_____

Does the family member have same or similar symptoms as the index patient?

☐ No ☐ Yes, symptoms are:_____

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

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INFORMATION FOR PATIENTS

A genetic test has been recommended for you, or for a person under your care, to help investigate specific health concerns. In accordance with the **German Genetic Diagnostics Act (GenDG)**, you must be informed about the test before it is performed and must provide **written consent**. The physician ordering the test is responsible for this process.

PROCEDURE OF GENETIC TESTING

Purpose of the test: The genetic analysis aims to identify alterations in your genetic material that may be responsible for your symptoms or conditions, or for diseases that are already known in your family. The results may support medical care, disease management, and family planning decisions.

Methods of testing: Various methods can be used for genetic testing, such as chromosome analysis (cytogenetic analysis) or DNA analysis (molecular genetic analysis). The best-suited method will be chosen by the laboratory based on the specific question to be answered. In some cases, a combination of methods may be used to increase the likelihood of detecting a genetic alteration.

Conducting the test: The test is typically carried out using a blood sample. The venipuncture generally poses no health risks.

The sample and results will be used only for the purpose of the requested test.

POSSIBLE RESULTS OF THE GENETIC TEST

Genetic test results are interpreted together with your clinical information, symptoms, medical and family history, and previous diagnoses. Results are confidential and are usually explained by your ordering physician, including any limitations, next steps, and possible unexpected findings. The following are possible results of the test:

1. Identification of a disease-related genetic alteration:
- If a (likely) pathogenic genetic alteration is identified that is linked to your condition, this indicates that the alteration is most likely the cause of your symptoms or condition.
- You will be provided with detailed information about the condition, including its progression and treatment options, if available.

2. No identification of a disease-related genetic alteration:
- Even if no disease-related genetic alteration is found, a genetic cause for your condition cannot be ruled out.
- This is due to the fact that not all clinical abnormalities can be genetically explained, as environmental factors may also play a role. Additionally, it is possible that the genetic cause could not be detected by the methods currently used.
- For this reason, a follow-up consultation and possibly a re-evaluation in 2-4 years is recommended if the results are unremarkable.

3. Identification of genetic alterations with unclear clinical significance:
- Sometimes, genetic alterations are identified whose clinical significance is not yet clear. These so-called variants of uncertain signifcance (VUS) may be either harmless or disease-related, but their effect is not yet fully understood at the time of testing.
- For this reason, a follow-up consultation and re-evaluation of the genetic analysis in 2-4 years is recommended for any identified VUS.
- You will be informed of such genetic alterations, and discussions will be held with you regarding their potential implications for your health and the health of your family.

4. Incidental and secondary findings:
- In comprehensive genetic analyses, such as exome or genome sequencing, clinically relevant genetic alterations may be identified that are unrelated to the original reason for testing. These findings are classified as incidental findings when they are discovered unintentionally while investigating the primary clinical question, or as secondary findings when they are deliberately and systematically searched for despite being unrelated to the original indication for testing.
- Example: In a test for a developmental disorder, a genetic predisposition to a heart arrhythmia may also be discovered.
- Your decision: You may specify in the consent form whether you wish to be informed of such findings. Typically, only those incidental or secondary findings are reported that are related to conditions for which medical treatment options are available, or preventive measures can be taken.

CONFIDENTIALITY AND DATA PROTECTION

Your genetic test results will be stored exclusively in a secure laboratory information system and are only accessible to authorised personnel. All data protection regulations will be adhered to according to the applicable legal requirements. The results must be stored for 10 years, after which the data will be destroyed unless you have made other arrangements. Please refer to our full Privacy Policy available on our website.

REVOCATION OF CONSENT

You can **revoke** your consent for the genetic test at any time, either fully or partially, without providing any reasons. You can also stop the test and request the destruction of the tested material before the results are communicated. However, any costs incurred prior to your objection may be charged.

FURTHER QUESTIONS?

If you have any questions about the methods, results, or any other aspects of the genetic test, please contact your responsible physician.

For additional information, please visit our website at www.medicover-genetics.com.

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