

Patient's full name

Clinical diagnosis / Indication for testing
/ Concomitant medications

Place of residence / hospital ward

Contact details (ie. tel., e-mail)

date of birth

D D / M M / Y Y Y Y

Sex

 Male
 FemaleTransfusion YES NOdp wp

date of issuing the referral note

D D / M M / Y Y Y Y

ORDER CODE

Stamp, name of the ordering party, National Business Registry Number, telephone

Place to send the examination report to or a person authorized to collect results

D D / M M / Y Y Y Y H H : M M

Date and time of material collection

Signature of the person collecting material

D D / M M / Y Y Y Y H H : M M

Date and time of receipt by INVICTA Laboratory

Signature of the person accepting material

MATERIAL TYPE **FFPE tissue** **Blood** **Saliva****ORDERED GENETIC TESTS**

- iMGE Test XY™ - Sex Determination – PCR Testing
- iMGE Test+™ - Products of Conception (POC) QF-PCR Testing (13, 15, 16, 17, 18, 21, 22, X, Y)
- iMGE Test 24™ - Products of Conception (POC) NGS Testing
- Chromosome Analysis (Blood)
- Chromosome Analysis (saliva) - QF-PCR aneuploidy diagnosis for 13, 15, 16, 17, 18, 21, 22, X, Y chromosomes

INDICATIONS FOR TESTING

* please mark as appropriate

Karyotype of peripheral blood lymphocytes

- Reproduction failures (2 or more miscarriages in a female patient of male patients' partner) of unexplained etiology
 - Male/female infertility of unexplained etiology
 - Carrier of chromosomal aberrations
 - Positive family history (if possible, please present the results of the family members' cytogenetic test results, description of defects)
 - Abnormal structure and/or function of reproductive organs, suggesting e.g. Turner syndrome or Klinefelter syndrome
 - Mental retardation an/ or dysmorphic features (please state the type and level of mental retardation)
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- significant growth deficiency of unexplained etiology in women
 - primary or secondary amenorrhea of unexplained etiology
 - Other - please state:

 TEST TOTAL

legible signature of the Patient

signature and name stamp of the referring physician

For the performance of genetic testing the patient's informed consent is required as provided on the second page of the referral.
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Declaration of Informed Consent for the purpose of DNA/RNA isolation and performance of molecular/cytogenetic diagnostic testing aimed at identification of changes in DNA in connection with suspected /diagnosed disorder:

I declare that:

1. I have been informed about the nature of suspected disorder and about the purpose and significance of genetic testing to be performed.
2. I consent/ do not consent* for the storage of the isolated DNA following the test completion and its anonymous use in genetic scientific research aiming at broadening the knowledge of the molecular background of genetic disorders.
I consent/ do not consent* that I will be informed in the future about the results of scientific research where they could constitute the basis for the diagnosis of genetic disorder or its enhanced progress.
3. In relation to the genetic testing of tissues from miscarriage I consent for the performance of genetic testing of material obtained from miscarriage for the purpose of determining whether the miscarriage was due to a chromosomal defect of the embryo/foetus.
4. I am aware of the fact that the collected material will be stored in appropriate conditions until the completion of all tests as well as of the fact that there is the risk of natural degradation of samples/preparations and, in consequence, another collection of material might be required.
5. I am aware that in certain situations test results may be inconsistent and in consequence, there may be the need to perform complementary tests.
6. I have been informed that where the relationship of consanguinity among the family members is different than stated, the interpretation of test results may be incorrect.
7. I have been informed that the obtained test results may indicate the need to collect biological material from other family members.
8. If, in the period between collecting material for testing and issuing test results a patient who is not of full age completes 18 years of age, she/ he will be required to sign the "Declaration of Informed Consent" form prior to issuing the test results.
9. I have been informed about the consequences of incorrect collection, storage, and transportation of material and I have understood this information.
10. I understand that the testing will be performed in relation to the material which has been provided by me or on my behalf and that a person receiving this material cannot check the quality of this material on receipt or decide on the possibility of test performance.
11. The material will be accepted and forwarded to the laboratory in accordance with the description on referral for testing. Invicta bears no responsibility for the content of the referral /order issued by a physician.
12. I have been informed that the testing techniques cannot warrant in full that minor chromosomal aberrations and chromosomal mosaicism cases will be detected.
13. I consent for the processing of my telephone number and email address, for receiving medical information via mobile network and electronic mail as well as for the collection and processing by Invicta sp. z o.o. of the data I have provided for the needs of the promotion of own services and informing me about new services and promotional actions. I consent for test performance in another laboratory if it proves necessary for the performance of the service.
14. I have been informed about the possibility of destruction of the biological samples after the test to which I have consented.
15. I give my consent, if the need arises, for the transportation and test performance outside the territory of the: (CENTER NAME)
 yes no
16. The genetic test is performed for the first time: yes no
(if yes):
Previously performed genetic test:
(TEST TYPE)
The test was performed at:
(CITY AND CENTER NAME)
17. I declare that the PATIENT'S DATA provided are true, I give my consent to collection.

.....
date

.....
full name of a patient/legal guardian

.....
date

.....
Doctor's signature

*Delete as appropriate