Patient	☐ male	☐ female	☐ divers
Last name, first name		Date of birth	
Street			
Zip code	City		

Fachbereich Humangenetik
Fetscherstraße 74, 01307 Dresden
Probenversand an:
Haus 137, 1. OG, Laborbereich
Tel. +49 (0)351 458 18349
Fachärzte für Humangenetik:
Prof. Dr. Diana Le Duc, MD/PhD; Prof. Dr. med. Min Ae Lee-Kirsch; Dr. med. Joseph Porrmann; Dr. med. Arne Jahn; Dr. med. Marcus Franke; Dr. med. Jan Fischer
Tel.: +49 (0)351 458 2891, Fax: +49 (0)351 458 4316
Email: genetische.ambulanz@uniklinikum-dresden.de

Consent according to the German Genetic Diagnostics Act (GenDG - http://www.gesetze-im-internet.de/gendg/)

Please make sure that your information is complete, otherwise it may not be possible to process it.

Physician and institution (stamp or printed letters)

Last name, first name	
Name of the institution	
Adresse	
Phone	

Cost unit

☐ Public health insurance / Referral Slip No. 6 (Joint treatment, no laboratory analysis)
☐ Public health insurance / Referral Slip No. 10 (Laboratory analysis without budget burden)
☐ §116b SGB V
☐ §140a SGB V
☐ UKD - in-patient
☐ Private health insurance Self payer / IGeL
☐ Invoice to sender / clinic
☐ Research based by agreement

Reason for Investigation

Disease / Diagnosis	
clinical, anamnestic and family anamnestic data	
Previous genetic findings	
Type of examination / method	

I consent to the electronic processing and storage of my personal and clinical data in database systems for Clinical Genetics. In accordance with the GenDG, I hereby consent to genetic testing in order to determine the genetic cause of the above-mentioned clinical condition and to the

Storage of sample material after completion of the examination order
a) for verification and quality assurance. ☐ yes ☐ no
b) for new diagnostic possibilites. ☐ yes ☐ no
Use of the examination results for counseling and testing family members with regard to the above mentioned clinical condition. ☐ yes ☐ no
Use of the surplus sample material for researching the causes and improving the treatment of genetic diseases, as well as publication of the pseudonymized results. ☐ yes ☐ no
Storage of the examination results for longer than 10 years. ☐ yes ☐ no
Forwarding of this test request to a specialized cooperation laboratory. ☐ yes ☐ no
Exchange of my pseudonymized data for the purpose of verifiability of the results and quality assurance with other institutions in compliance with data protection. ☐ yes ☐ no
Recontacting in the event of new medically relevant findings. ☐ yes ☐ no
Sending of the genetic test results to the referring physician. ☐ yes ☐ no

The communication of the findings is always carried out in accordance with the German Genetic Diagnostic Act (Gendiagnostikgesetz).

The reports on the findings of the examination or the treatment reports should also be sent to:

Surname, first name, institution, location of other attending physicians

IMPORTANT: Reporting of additional findings: If incidental medical findings are obtained that are not related to the above-mentioned clinical question and the respective disease group, but which, according to the current state of knowledge (based on the recommendations of the American College of Medical Genomics, ACMG), could have possible implications for disease prevention, screening or treatment for me or my family, I would like to be informed about these. No guarantee of completeness is given. ☐ yes ☐ no

I can revoke this consent in whole or in part at any time.

I have received and understood a detailed explanation of the planned genetic tests in accordance with the GenDG. I had the necessary time to think about it. All my questions were answered comprehensively.

In addition to the information sheet in accordance with the GenDG, I have received a copy of the consent ☐ / I waive a copy of the consent ☐.

Alternatively: Confirmation by the medical person providing information: I have the consent of the patient or the legal representative.

Place, Date

Signature patient or legal representative

*First name, surname of patient or legal representative in **printed letters***

Signature of informing physician

*First name, surname, **stamp or printed letters** Informing physician*