



Order form

Prenatal Medicine Munich
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Germany

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Email: molekulargenetik@praenatal-medizin.de

Patient female / male Ethnic origin _____

Last Name

First Name

DOB

Street

ZIP code and City/Country

Billing information

- VISA/ MasterCard
- E112 (applicable within European Union)
- bill hospital (provide exact billing address)

Suspected Indication and Clinical data

Family History: Positive Negative Unknown

Infectious sample: HIV, e. g. or other, please state _____

Referring Institution / Health care professional

Name of referring physician (please print)

Street, ZIP code, City/Country

Phone

Email address

report to: _____

Signature of patient (in case of minors, the parents):

With this signature I confirm, that I was fully informed about the nature and extend of the planned DNA diagnostic testing. I explicitly consent to the testing and the blood taking.

City, date

Signature (patient/parents)

Alternatively, confirmation of the referring physician:

Hereby, I confirm that the patient has consented to the DNA testing and the blood taking after the nature and extend of the DNA testing was explained.

City, date

Signature (patient/parents)

Signature referring physician

Pränatal-Medizin München
Frauenärzte und Humangenetiker (MVZ)
Dr. med. Karl-Philipp Glöning
Dr. med. Sabine Minderer
Priv.-Doz. Dr. med. Thomas Schramm
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Zertifikat ISO 9001:2008

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