Pränatal-Medizin München

Order form

Prenatal Medicine Munich
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D-80639 Munich
Germany

Phone +49 89 130744-22
Fax +49 89 130744-99

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 (appplicable 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