REQUEST FORM : HEREDITARY ONCOGENOMIC ANALYSIS

Centre hospitalier universitaire vaudois

Service d'hématologie
Laboratoire d'oncogénomique

Réception des laboratoires BH18-100
1011 Lausanne

Tel. : 021 314 33 93
Fax : 021 314 34 44
e-mail : log@chuv.ch

http://www.chuv.ch/log

Laboratory opening hours:
Monday-Friday 8am – 5pm

PATIENT

Surname :

Name :

Adress :

Date of birth :

Sex : ☐ Male ☐ Female

Ref. :

Sample date:

BILLING
☐ Patient
☐ Requester

Insurance agreement
☐ Yes
☐ No

MATERIAL (to stock at room temperature)
☐ Blood (lithium heparin or EDTA)
☐ Skin biopsy
☐ Buccal swab
☐ Saliva

If requesting an analysis on a sample already stocked at the laboratory :

Sample date :

PROVENANCE

Clinician :

Tel./BIP :

Hospital :

Departement :

☐ Screening
☐ Family test

Analysis for a known variant :

Family pedigree :

DIAGNOSTIC contextuel à la demande d'analyse

GENETIC CONSENT

TO FILL IN AND SIGN :

→**Please see next page**

Next generation sequencing (NGS) :

☐ **IBFM Panel (**Inherited **B**one **M**arrow **F**ailure**) :**

☐ ACD	☐ DNAJC21	☐ JAK2	☐ PARN	☐ SAMD9	☐ TRNT1
☐ ACTN1	☐ ELANE	☐ LBR	☐ PRF1	☐ SAMD9L	☐ WAS
☐ ALAS2	☐ ERCC6L2	☐ LIG4	☐ RBBP6	☐ SBDS	☐ WRAP53
☐ ANKRD26	☐ ETV6	☐ MBD4	☐ RPL11	☐ SRP72	
☐ ATG2B	☐ GATA1	☐ MECOM	☐ RPL35A	☐ STIM1	
☐ ATR	☐ GATA2	☐ MPL	☐ RPL5	☐ TERC	
☐ CEBPA	☐ GFI1	☐ MYH9	☐ RPS19	☐ TERT	
☐ CTC1	☐ GSKIP	☐ MYSM1	☐ RPS26	☐ THPO	☐ Full panel (53 genes)
☐ DDX41	☐ GSN	☐ NHP2	☐ RTEL1	☐ TINF2	
☐ DKC1	☐ HAX1	☐ NOP10	☐ RUNX1	☐ TP53	

☐ **RB1 Panel (including MLPA and SNP array)**

☐ **RB1 Linkage analysis (fragment analysis)**

Swiss Society of Medical Genetics

Informed consent for genetic testing

December 2015

Surname: _____ First name: _____

Date of birth: _____

I confirm that in the context of a genetic counselling session I've been informed about the different aspects of genetic testing as explained in the information sheet „Information for patients". I have understood the information and had sufficient time for decision making.

I give my consent for the following genetic analysis/es:

_____ ☐ prenatal ☐ postnatal ☐ predictive/presymtomatic

For the following **disorder**: _____

Based on the following **biological sample** (e.g. blood, amniotic fluid, tissue sample):_____

Incidental findings: Should the analysis/es reveal results not directly related to the testing requested (so called "incidental findings"), I wish to be informed as follow:

- Carrier of a disorder for which preventive and/or therapeutic measures are available ☐ YES ☐ NO
- Carrier of a disorder for which no preventive / therapeutic measures are yet available ☐ YES ☐ NO
- Healthy carrier of a recessive disorder which could concern the following generation or other family members ☐ YES ☐ NO
- Other decisions _____

Should these questions remain unanswered it will be assumed that the patient does NOT want to be informed about incidental findings.

Storage and use of the remaining biological material and data for further analyses.

- I agree that the remaining biological material and data will be stored for possible further analyses. My informed consent will be necessary should further analyses be requested. ☐ YES ☐ NO
  In case of a negative answer the remaining biological sample will be destroyed after the analysis!
- I agree that my biological sample and data are used anonymously for quality testing ☐ YES ☐ NO

The use of your sample and data for research purposes.

Should you agree in principle to participate in research studies you could indicate this below. Should this be the case you would be contacted at a later stage with details concerning the research projects. A positive answer below is **not yet consent** for the participation in any actual research projects**.**

- In principle, I agree that my biological sample and data could be used for research purposes ☐ YES ☐ NO

Signature: _____ Place and date: _____
(Patient or parent/legal guardian)

Medical counsellor:

I declare that I've informed the above mentioned person/s, according to the law on genetic testing on humans (GUMG), about the planned genetic tests and their limits as well as providing answers to the patient's questions.

Surname:_____Name: _____

Signature:_____Place and date:_____Stamp :