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ANALYSEN-ANFORDERUNGSSCHEIN

Stempel des/der zuweisenden Arztes/Ärztin

Surname _____ First name _____

Date of Birth _____ Ins.Nr. _____

Medical insurance _____ ☐F ☐M Phone _____

Adress _____

Diagnosis _____

Date _____

Request / Informed consent concerning genetic analysis

☐Faktor V Leiden (75 €)	☐Haemochromatosis (80 €)	☐ Apolipoprotein E (80 €)
☐Lactose Intolerance (60 €)	☐Familial Mediterranean Fever (690 €)	☐ Apolipoprotein B (80 €)
☐Prothrombin (75 €)	☐CAG Repeat Length Polymorphism within the Androgen-Receptor Gene (90 €)	
☐ _____		

(Costs valid from August 1st 2016)

I was informed by my referring physician about the current Austrian gene technology law concerning the nature, scope and significance of the planned genetic analysis and agree with the performance of the genetic analysis.

In case of a predictive genetic testing (analysis of a risk-factor in healthy people), the report will be sent exclusively to the referring physician and will be handed over to me in the course of a genetic counselling session.

The analysis can only be done if this agreement, signed by the patient and the doctor, is available.

Signature*: _____

* Children under 14: signature of parent or legal guardian is required.

Referring Physician

Name (in capital letters): _____

Signature: _____

Date: _____