Health insurance company or carrier

Last name, first name and adress of insured person

DOB

Health insurance No. | Insured No. | Status

Facility No. | Doctor No. | Date

Responsible doctor (Stamp)

PrenaTest®

WM-3050-EN-003

Mandate reference for SEPA direct debit mandate:

Attach barcode label or enter barcode number

For internal purposes

LCD/LCB

Send the original together with the blood sample in the return box.

To be completed by the doctor

Information on the pregnancy

Date of blood draw (DD/MM/YYYY)

☐ Repeat blood sample (if 1st analysis is failed)

Week of pregnancy: + p.m. (at least week 9+0 to 32+1 p.m.)

☐ **Patient is receiving low-molecular-weight heparin (LMWH)**

☐ **Singleton pregnancy**

Body height: cm

☐ **Twin pregnancy** Monochorionic: ☐ **Yes** ☐ **No**

Weight prior to pregnancy: kg

Reason for the genetic examination

☐ Age 35 years and over at the time of the birth

☐ Prior pregnancy with fetal aneuploidy

☐ Increased risk of aneuploidy based on screening methods for prenatal risk determination

☐ Ultrasound anomalies of the fetus

☐ Hereditary risk of fetal aneuploidy

☐ Other medical reasons/additional pregnancy info (e.g. vanishing twin)

Results report (Multiple languages may be selected for results report)

☐ **German** ☐ **English** ☐ **French** ☐ **Italian** ☐ **Dutch** ☐ **Turkish**

Requirement according to the German Genetic Diagnostics Act

I confirm that the abovementioned patient received human genetic counseling and explanations in accordance with the German Genetic Diagnostics Act. The patient's written consent for the selected genetic testing (PrenaTest® test option 1, 2 or 3) is available. I hereby confirm the order for genetic analysis using the PrenaTest® by LifeCodexx AG in accordance with section 7 of the German Genetic Diagnostics Act. The blood sample comes from the patient named on this form, provided that the barcode numbers on the blood sample test tube and on the form agree or the patient can be clearly identified by name and date of birth on the test tube and form. **Note:** If less than 3 mL of plasma can be obtained from each of the two blood samples, the plasma from the two blood samples will be combined in order to be able to perform a PrenaTest® analysis. If this total quantity is insufficient, a new blood sample will be requested.

Place, Date

Signature of the responsible doctor

✗

Order to perform the PrenaTest®

Prices include VAT and shipping

* According to the GenDG, notification by the doctor starting at pregnancy week 14+0 since LMP

☐ **Test option 1**	☐ **Test option 2**	☐ **Test option 3**
EUR 199	**EUR 299**	**EUR 399**
Determination of fetal trisomy 21 for singleton pregnancy, incl. gender determination on request	**Determination of fetal trisomies 21, 18 and 13** for singleton or twin pregnancy, incl. gender determination on request	**Determination of fetal trisomies 21, 18, 13 and gonosomal aneuploidies** for singleton pregnancy, incl. gender determination on request
Gender determination* desired ☐ **Yes** ☐ **No**	**Gender determination* desired** ☐ **Yes** ☐ **No**	**Gender determination* desired** ☐ **Yes** ☐ **No**

To be completed by the patient

Written agreement on self-pay services

I would like to have the PrenaTest® performed through my responsible doctor as a private patient. The request was not made at the initiative of my doctor. The service I am requesting is not a component of care provided by statutory health insurance doctors. I will pay for the PrenaTest® myself. I am responsible for clarifying whether costs will be reimbursed on a case-by-case basis by my health insurance company. **My signature provided herewith is independent of an agreement regarding cost reimbursement by my health insurance company.**

SEPA direct debit mandate – Creditor ID: DE 35ZZZ00000415178

Only fill out if you have a German bank account! If not, transfer the payment in advance to LifeCodexx AG, IBAN DE88 6905 0001 0024 4035 52, Swift-BIC SOLADES1KNZ, Sparkasse Bodensee. I/we hereby revocably authorize LifeCodexx AG to collect the amount to be paid by me/us according to the test option selected above following report of results to the responsible doctor. If my full address is on hand, I will receive an invoice after receipt of payment. Even if I waive communication of the investigation results, I am obligated to pay for the services rendered. I have taken note of the General Terms and Conditions.

First and last name of the account holder

IBAN/account no. | BIC/bank sort code

Credit institution | Place, Date | **Signature of the patient/authorized account user** ✗

Consent to perform the PrenaTest®

With my signature, I hereby give my consent to have the PrenaTest® performed. I received human genetic counseling and explanations from my responsible doctor in accordance with the German Genetic Diagnostics Act (GenDG). I have taken note of the General Terms and Conditions (see reverse).

Collected data/results not identified by name may be used for scientific purposes and published in anonymized form in professional journals. ☐ **Yes** ☐ **No**

Surplus examination material that is not identified by name may be stored for purposes of quality assurance, scientific research, and the development of new diagnostic options. ☐ **Yes** ☐ **No**

Telephone number of the patient

E-Mail address of the patient

Place, Date

Signature of the patient ✗

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