Order for genetic testing

Health insurance company or carrier

Last name, first name and address of insured person

DOB

Health insurance No. | Insured No. | Status

Facility No. | Doctor No. | Date

Responsible doctor (stamp)

WM-3090-EN-004

Mandate reference for SEPA direct debit mandate:

Attach barcode label
or enter barcode number

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

Singleton pregnancy | Twin pregnancy

PraenaTest®

gestational week 9 + 0 to 32 + 1 p.m.

☐ **Option 1**	Trisomy 21	129.– Euro
☐ **Option 2**	Trisomies 21/18/13	228.– Euro
☐ **Option 2 *Plus***	Trisomies 21/18/13, rare autosomal aneuploidies (RAA*)	378.– Euro
☐ **Option 3**	Trisomies 21/18/13, gonosomal aneuploidies (X/Y)	268.– Euro
☐ **Option 3 *Plus***	Trisomies 21/18/13, gonosomal aneuploidies (X/Y), RAA*	418.– Euro

* RAA: examination of the autosomal Chr. 1 – 12, 14 – 17, 19 – 20, and 22 for monosomy & trisomy as well as Chr. 13, 18, 21 for monosomy.

Additional PrenaTest® options

☐ **Fetal gender** – / all options ☐ Ergebnis erst in SSW 14 + 0 p.m.**	kostenfrei
☐ **22q11.2 microdeletion** – / not for option 1. **Please read the fact sheet!**	39.– Euro

** i.e. week 12+0 p.c. according to § 15 Abs. 1 GenDG

☐ **Post analysis 22q11.2 microdeletion** – / without new blood sample — 69.– Euro
Based on PrenaTest® order not older than 3 months (not for option 1). **Please read the fact sheet!**
Order by Fax: 07531-9769480
Prior barcode no.

NIPD-RhD

gestational week 11 + 0 p.m.

Non-invasive prenatal RhD genotyping from maternal blood for RhD negative women.

Important: Patient MUST NOT receive LMWH! Please read the fact sheet!

☐ **NIPD-RhD** – / in combination with PraenaTest®	plus 129.– Euro
☐ **NIPD-RhD** – / single request	149.– Euro

Conception date (DD/MM/YYYY)

Geographic origin	Patient	Procreator
Europe	☐	☐
North Africa	☐	☐
Africa / Caribbean	☐	☐
Middle East	☐	☐
Asia	☐	☐
Other		

Prices are including VAT and transport.

To be completed by the doctor

Date of blood draw (DD/MM/YYYY)

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

☐ Singleton pregnancy ☐ Twin pregnancy

Gestational week + p.m.

Other Information (e.g. vanishing twin)

Body height cm

Weight prior to pregnancy kg

Request according to the German Genetic Diagnostics Act (GenDG)

I provided human genetic counseling and information to the abovementioned patient in accordance with the German Genetic Diagnostics Act. The patient's written consent for the selected genetic test is available. I hereby confirm the order for the genetic test(s) selected above by Eurofins LifeCodexx and Eurofins Biomnis, France, in the case of NIPD-RhD, in accordance with section 7 of the German Genetic Diagnostics Act.

Name of the responsible doctor

Fax-Nr. for result reports

Place, date | **Signature of the responsible doctor** ✗

Result report for PraenaTest® (NIPD-RhD: EN only)

☐ DE ☐ EN ☐ ES ☐ FR ☐ IT ☐ NL ☐ TR ☐ RO ☐ RU

To be completed by the patient

Agreement on a self-pay service

Through my responsible doctor, I would like to have the genetic test(s) – which is/are not a component of care provided by statutory health insurance – performed as a private patient. The request was not made at the initiative of my doctor. I am paying personally for the testing. **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

I/we hereby revocably authorize Eurofins LifeCodexx to collect the amount(s) to be paid by me/us according to the selected genetic test(s) following a separate report of results to the responsible doctor. If my address is on hand, I will receive the invoice(s) after receipt of payment. Even in the event of a revocation, I must pay for services rendered.
No German bank account? Please transfer the total amount in advance to Eurofins LifeCodexx, IBAN DE83 2073 0017 7000 0034 50, Swift-BIC HYVEDEMME17, UniCredit (HypoVereinsbank).

First name of the account holder

Last name of the account holder

IBAN D E

Place, date | **Signature of the authorized account user / the patient** ✗

Consent to conduct the genetic test(s) and to use of data

With my signature, I grant my consent for the genetic test(s) selected above to be performed. I received human genetic counseling and information from my responsible doctor in accordance with the German Genetic Diagnostics Act (GenDG). I consent to my personal data collected hereby and my blood sample for conducting the genetic test(s) being transmitted to, processed by and used by Eurofins LifeCodexx (and Eurofins Biomnis, France, in the case of NIPD-RhD). I may at any time revoke my consent given to my responsible doctor. In the event of revocation, any processing of my personal data which has taken place until that time remains lawful.

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

I have taken note of the General Terms and Conditions and of the Notes on Data Protection (see reverse).

Place, date | **Signature of the patient** ✗

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