MGZ
Medical Genetics Center

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All forms are available on our website:
www.mgz-muenchen.com

TEST REQUEST FORM

ilac-MRA DAkkS Deutsche Akkreditierungsstelle D-ML-13242-01-00

The accreditation is only valid for the scope of accreditation specified in certificate.

- Patient Surname, First Name:
- Internal Patient or Sample ID: Date of Birth:
- Sample Collection Date: Sex: Male Female

☐ urgent

- Either check the box(es) next to the test(s) you request on pages 2-6 of this form OR write the name(s) of the test(s) you request here:
- Has the patient had previous testing at MGZ – Medical Genetics Center? ☐ Yes ☐ No
- Have any genetic tests already been performed? ☐ Yes ☐ No
- Please indicate clinical diagnosis, symptoms, test results, and family history:

Requesting clinician (for forwarding of test results report and follow-up questions):

Name of physician or genetic counselor:

Email (required):

Address (required):

Send report by:

☐ **Email:** (see email address written on the left)
☐ **Fax:**
☐ **Post:** (see post address written on the left)

☐ **I, the requesting clinician, certify that the patient, or his/her legal representative, has been given an explanation of the possible results and implications of undergoing the genetic test requested, has been given the opportunity to ask questions, and is voluntarily choosing to pursue this test.**

Cost carrier:

☐ **Invoice to patient**
☐ **Invoice to institution**
☐ **E112 (EU only)**

Send invoice by:

☐ **Email:**
☐ **Fax:**
☐ **Post:**

Payment agreement:

☐ **We agree to the costs of the test listed in the cost statement provided (enclose copy) ***

* MGZ reserves the right to request payment in advance of genetic analysis. Upon receipt of this test request, you will be informed if you are required to pay in advance.

Date

Signature of patient/legal representative OR representative of institution covering costs

Stand 2023-07

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