Analysis request form Pill Protect ®

GENE PREDICTIS® S.A.
Medical analyses laboratory
EPFL Innovation Park, Bâtiment B – CH-1015 Lausanne
Ph:+41 21 691 43 75– Fax: +41 21 691 43 76 - labo@genepredictis.com
Head of Genetics: Dre K. AFSHAR PhD, FAMH Medical Genetics

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BECAUSE I AM UNIQUE

PATIENT DATA	REQUESTING PHYSICIAN
☐ Male ☐ Female ☐ Other	(Stamp or contact details and RCC number)
Last name:	
First name:	
Date of birth:	**Copy to :**
Address 1:	**Please write the report in:**
Address 2:	❒ French ❒ English
Postal code:	❒ German ❒ Italian
Locality:	**Translation requested in (extra[1]):**
Health insurance:	❒ Russian ❒ Spanish
Insured number:	❒ Simplified Chinese
AVS13 No. 756.	**Date of collection:**
Primeo : ❒ Oui ❒ Non	❒ Buccal swab ❒ Sang-EDTA

INVOICE: ❒ Insurance ❒ Physician ❒ Patient ❒ Other (provide full contact information below)

Indication:

Clinical information:

Weight	……Kg		
Height	……m		
Smoking	❒ yes	❒ no	❒ former ……. cig/day
Alcohol	❒ yes	❒ no	……. glasses/day
Physical exercise	❒ yes	❒ no	……. hours/week
Hypertension	❒ yes	❒ no	
Thrombosis/pulmonary embolism	❒ yes	❒ no	Details :
Cardiovascular diseases	❒ yes	❒ no	
Cholesterol	❒ yes	❒ no	
Diabetes	❒ yes	❒ no	
Allergies (food and drug) :			
Menopause	❒ pre	❒ post	
Other diseases :			

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Contraceptive pills for which a risk estimation is requested (maximum 3):

Current contraception :
Duration of current contraception:

Former contraception (name and duration) :

Other current treatments (name and dosage) :

Familial anamnesis

Cardiovascular diseases	❒ yes	❒ no	relationship and details :
Thrombosis/Embolism	❒ yes	❒ no	relationship and details :
Diabetes	❒ yes	❒ no	relationship:
Osteoporosis	❒ yes	❒ no	relationship:
Obesity	❒ yes	❒ no	relationship:
Hypertension	❒ yes	❒ no	relationship:
Other diseases	……..		

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INFORMED CONSENT IN VIEW OF GENETIC TESTING

Last name: …… First name: ……..…… Date of birth: …….

"I certify with my signature that I have received genetic counselling and that enough time for questions and reflection has been provided.

I hereby agree to have the indicated genetic test(s) done:

❒ Molecular analysis for diagnostic of a genetic disease (name of the disease): ……..

❒ Pharmacogenetics: molecular analysis of my DNA for the determination of polymorphisms or genetic variants related to the metabolism of drugs that I am taking or that I will take.

❒ Molecular analysis of my DNA for disease susceptibility and/or predisposition according to Gene Predictis® profiles

Material for the analysis: ❒ Buccal swab ❒ Blood

My decision for the conservation of the sample after the test is completed:

I agree that after completion of the test, my sample(s) will be stored for future analysis in my interest, and only upon my request. ❒ YES ❒ NO

If you select NO, the material will be discarded after analysis.

I agree with storage and utilisation of my genetic material and my data analysis after anonymization for improvement of the quality of genetic tests. ❒ YES ❒ NO

My decision regarding utilisation of my results for research

In addition, your samples and analysis data can be useful for research. If you are interested in possibility of participating in a research project, you can indicate it here. If necessary, we will contact you to give you more information. At this stage, your response does not imply any commitment from your part.

In principle, I agree to my sample and data being stored and used for research. ❒ YES ❒ NO

My e-mail address: _____

Signature: …… Place and date: ……..
(parent/legal representative when applicable)

Referring physician:

"I have given an appropriate explanation of the test and its limits to the sub-mentioned patient and I have appropriately answered to patient's questions conforming to the law on genetic testing in human (LAGH)."

Name of the referring physician: …….
Domicile of the referring physician: ……
Place and date: …….. Signature and stamp: ……..…