Analysis request form

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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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:

GENETIC ANALYSES GENE PREDICTIS® SA

❒ MTHFR	❒ Lactose intolerance	❒ Exfoliation glaucoma
❒ FV	❒ Gluten intolerance	❒ AMD (Macula)
❒ FII	❒ Fructose intolerance	❒ Hemochromatosis
❒ HLA-B27	❒ GLU-LCT	
❒ Other specific genetic analysis:		

GENETIC PROFILES GENE PREDICTIS® SA[2]

❒ CYPASS®	❒ EYES	❒ SPORT
❒ Extended CYPASS®	❒ CARDIO	❒ STATINS
❒ NUTRIPASS®	❒ THROMBO-E2	❒ NICOTINE
❒ BETTER AGEING	❒ OSTEO	❒ ALCOHOL
❒ EXCLUSIVE	❒ DETOX	
❒ Other specific profiles:		

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[1]**Additional fee** for translation of the report: 300 CHF for all profiles except for **GP-NUTRIPASS** and **GP-EXCLUSIVE** 500 CHF. **Translation requires 3 to 5 additional days.**

[2] **The analysis will be performed upon receipt of payment** at the following account number (**do not forget to mention the analysis number in the payment**, **ex: 362-101**): Banque Cantonale de Fribourg, en faveur de Gene Predictis SA, Numéro du compte 30 01 100.583-07, Clearing bancaire 768, IBAN : CH05 0076 8300 1100 5830 7, CCP : 17-49-3, Swift/BIC: BEFRCH22. **Consultation fee are not included in GP profiles bill**.

PATIENT ANAMNESIS

Weight	……Kg
Height	……m
Smoke	❒ yes ❒ no ❒ former smoker ……. cig/day
Alcohol	❒ yes ❒ no ……. glasses/day
Exercise	❒ yes ❒ no ……. hours/week
Sunlight exposure	❒ yes ❒ no ……. hours/day
Hypertension	❒ yes ❒ no
Cardiovascular diseases	
Cholesterol	
Diabetes	
Allergies	
Drug allergies	
Kidney disease	
Liver disease	
Cancer	
Menopause	❒ pre ❒ post
Other diseases	

FAMILY HISTORY

Cardiovascular diseases	❒ yes ❒ no relationship : Details :
Diabetes	❒ yes ❒ no relationship :
Osteoporosis	❒ yes ❒ no relationship :
Cancer	❒ yes ❒ no relationship : Type:
Obesity	❒ yes ❒ no relationship :
Hypertension	❒ yes ❒ no relationship :

Macular degeneration	❒ yes ❒ no relationship :
Glaucoma	❒ yes ❒ no relationship :
Other diseases	

CURRENT TREATMENT

Drugs (dosage)	
Nutritional supplements (dosage)	

NUTRITION (only for GP-NUTRIPASS™)

Milk consumption	❒ yes ❒ no ……. glasses/day
Dairy products consumption	❒ yes ❒ no What products ……
Fish consumption	❒ yes ❒ no ……. times/week What kind …….
Red meat consumption (beef, lamb, horse)	❒ yes ❒ no ……. times/week
White meat consumption (pork, poultry, veal, etc)	❒ yes ❒ no ……. times/week
High temperature grilled meat	❒ yes ❒ no ……. times/week
Egg consumption	❒ yes ❒ no ……. times/week
Fruit consumption	❒ yes ❒ no ……. times/day What kind:

Vegetable consumption	❒ yes ❒ no ……. times/day What kind :
Soy-derived product consumption	❒ yes ❒ no ……. times/week
Coffee/tea consumption	❒ yes ❒ no ……. glasses/day
Soft drink consumption	❒ yes ❒ no ……. glasses/day
Gluten-containing product consumption (pasta, bread, cereals)	❒ yes ❒ no ……. times/week
Fast food consumption	❒ yes ❒ no ……. times/week
Olive oil consumption	❒ yes ❒ no ……. spoons/day
Linseed oil consumption	❒ yes ❒ no ……. spoons/day
Canola oil consumption	❒ yes ❒ no ……. spoons/day
Butter consumption	❒ yes ❒ no ……. mg/day
Other oil consumption	❒ yes ❒ no ……. spoons/day What kind:

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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

For the prescription of the tests CYPASS, CYPASS EXTENDED, CYPASS-PSYCHIATRY, EXCLUSIVE or BETTER AGEING, your results can be stored in an encrypted database.

I hereby authorize Gene Predictis SA to add the results of my genetic analyses in an encrypted database constituted and administered by Gene Predictis SA or under its supervision by third parties bound by confidentiality obligations. The data pertaining to me will be accessible to Gene Predictis SA only. I hereby consent to the possibility of Gene Predictis SA making such data available via a website managed by Gene Predictis SA, provided that access to the website shall be restricted by a password and that such password shall only be communicated to me and not to my referring physician (subject to possible access to the data by the database administrator subject to confidentiality). ❒ 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: ……..…