GERMANO DE SOUSA
CENTRO DE MEDICINA LABORATORIAL

Please paste here the patient identification or provide the following data:

NAME

DATE OF BIRTH / /

REQUISITION OF POSTNATAL GENETIC STUDIES

I. REQUESTING ENTITY

REQUESTING PHYSICIAN

EMAIL TELEPHONE

II. SAMPLE SENT

COLLECTION DATE / /

III. CLINICAL INFORMATION

1. WHICH OF THE FOLLOWING HYPOTHESES JUSTIFIED THE REQUISITION OF THE STUDY

○ MENTAL RETARDATION ○ DYSMORPHIC / MALFORMATIONS PLEASE BRIEFLY DESCRIBE THE MOST RELEVANT CHANGES

○ GENITAL AMBIGUITY

○ GROWTH RETARDATION/POOR PROGRESSION (STATURO-PONDERAL) CM (PERCENTILE:) WHEIGHT KG (PERCENTILE:)

○ PRIMARY AMENORRHEA ○ SECONDARY AMENORRHEA ○ EARLY MENOPAUSE

○ INFERTILITY ○ COUPLE WITH REPETITIVE ABORTIONS IF SO, NO. OF SPONTANEOUS ABORTIONS:

○ FAMILY WITH CHROMOSOMAL ALTERATIONS WHAT'S THE CHANGE? DEGREE OF KINSHIP:

2. WHAT IS THE SUSPECTED DIAGNOSIS?

○ TRISOMY 21 (DOWN'S SYNDROME)	○ TRISOMY 18 (EDWARDS SYNDROME)	○ TRISOMY 13 (PATAU SYNDROME)
○ TURNER'S SYNDROME (45,X)	○ KLINEFELTER'S SYNDROME (47,XXY)	○ X-FRAGILE SYNDROME
○ ANGELMAN'S SYNDROME	○ PRADER-WILLI SYNDROME	○ CATCH 22 (S. DIGEORGE, VELOCARDIOFACIAL)
○ WILLIAMS SYNDROME	○ LEJEUNE SYNDROME ('CAT'S MEOW' – 5P-)	○ WOLF-HIRSCHORN (4P-)

○ OTHER CHROMOSOME ANOMALY WHAT?

3. OTHER INFORMATION IT DEEMS RELEVANT

IV. INTENDED ANALYSIS (PLEASE MENTION ALL THE EXAMS REQUESTED IN THE TERM OF RESPONSIBILITY

○ KARYOTYPE	○ STUDY BY FISH FOR THE SITUATION INDICATED ABOVE
○ ARRAY LOW RESOLUTION (ACGH)	○ ARRAY HIGH RESOLUTION (SNP ARRAY)
○ MOLECULAR RESEARCH OF FRAGILE X	○ OTHER STUDY. WHAT?

INFORMED CONSENT

I **CONSENT** to having the above genetic testing performed on which I was previously clarified in a clear and objective way on the application and limitations of the same.

I **AUTHORIZE** the collection of the biological sample required to perform the genetic test(s) indicated by the Germano de Sousa Laboratory Medical Center or, where necessary, by other laboratories designated by the same.

I **AUTHORIZE** that the data contained in this form are registered and processed only by duly authorized professionals, guaranteeing the protection and confidentiality according to the law in force.

I **GIVE MY CONSENT** for the result(s) to be sent to the prescribing physician.

I **HAVE BEEN INFORMED** of my right to revoke consent at any time without justification by sending an email.

SIGNATURE OF THE PATIENT OR THE LEGAL RESPONSIBLE (MINOR OR MAJOR INCAPABLE) OBLIGATORY

SIGNATURE OF THE DOCTOR OBLIGATORY

CONTACT FOR SUBMISSION OF RESULTS OBLIGATORY

IMPORTANT: Send the sample on the day of harvest. Do not send on Friday, not on the eve of holiday (consult central laboratory)