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

- Inquiry / Order Number:
- Patient Last Name, First Name:
- Date of Birth:
- Internal Patient or Sample ID:
- Sex: ◯ Male ◯ Female
- Sample Collection Date:

☐ urgent

- Test Request:
- 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, previous test results, and family history:

ORDERING

Requesting Clinician (for forwarding of test report and follow-up questions)

Name:

Email (required):

Address (required):

Send report by:

☐ **Email:** (see email address entered on the left)

☐ **Post:** (see post address entered on the left)

Send report in: ◯ English ◯ German

☐ I, the requesting clinician, certify that the patient, or his/her legal representative, has been given an explanation of the possible consequences and implications of undergoing genetic testing, has been given sufficient time and opportunity to ask questions, and has consented to genetic testing in accordance with national and regional laws.

☐ I have enclosed a signed patient consent form or copy thereof

Date (dd/mm/yyyy) Signature of Clinician

BILLING

(Please complete for offline orders and E112 option)

Cost carrier:

◯ Patient
◯ Clinic
◯ E112 (EU only)

Send invoice by:

☐ Email:
☐ Post:

Payment agreement:

Your order will be invoiced the amount stated in the inquiry email reply, as obtained through MGZ's online portal or a cost statement.*

By placing an order, you agree to the General Terms and Conditions of MGZ GbR, available at www.mgz-muenchen.com.

* MGZ reserves the right to request payment in advance of genetic analysis.

Date (dd/mm/yyyy) Signature of patient/legal representative OR representative of institution covering costs

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