SOFIVA GENOMICS

Genetic Testing Submission and Consent Form

Patient Information

Sample No._____

Disease/Target Gene			
Name		**Date of Birth** (dd/mm/yyyy)	/ /
ID/Passport No.		Gender	☐ Male ☐ Female
Mobile Phone No.		Nationality	
Address			

Clinical Information

Medical Record No.		**Collection Date** (dd/mm/yyyy)	/ /
Hospital/Clinic		**Physician** (Signature)	
Pediatric/General Test	Specimen Type: ☐ Blood (EDTA tube) ☐ Other_____		
Prenatal Test	Specimen Type: ☐ Amniotic Fluid: _____ml (greater than 10 ml) Appearance: ☐ Clean ☐ Turbid ☐ Brown ☐ Sanguine ☐ Villi ☐ Cord Blood ☐ Cord ☐ Placenta ☐ Other_____		
	Obstetric history: Gestation: _____ weeks (Ultrasound) Gravida: ____ Stillbirth: ____ Spontaneous Abortion: ____ Artificial Abortion: ____ Abnormal Infant: ____ Disease: _____		
Genetic locus of family inheritance	☐ Known_____ ☐ Unknown		
Pedigree and Clinical Details			

I, the undersigned, hereby fully understand, agree and undertake the following:

1. In rare cases, poor sample quality (for example, due to coagulation, hemolysis, or insufficient sample volume) will require a repeat sampling to ensure the accuracy of the test.
2. I hereby agree that the hospital/clinic and Sofiva Genomics may collect, process or use my personal information such as medical records, medical treatment, genetic information and health examination records under the specific purpose of medical care, health treatment etc.
3. I ☐agree / ☐do not agree to allow the remainder of my sample to be used for research purposes. (Lack of response indicates consent.)

_____

Signature, Date (dd/mm/yyyy)

Copy 1: Laboratory Retain (White) Copy 2: Hospital/Clinic Retain (Blue) Copy 3: Patient Retain (Red)