|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Identification (Please fill out in CAPITAL letters)** | | | | |
| Family Name Father | … | | | |
| First Name Father | … | | | |
| Date of Birth Father | … | | | |
| Ethnic Origin Father (*the country from where your parents and grandparents originate*) | … | | | |
| Family Name Mother | … | | | |
| First Name Mother | … | | | |
| Date of Birth Mother | … | | | |
| Ethnic Origin Mother (*the country from where your parents and grandparents originate*) | … | | | |
| Pregnancy ? |  | Yes |  | No |
| … | Weeks |  | |
| Address | … … | | | |
| Telephone | … | | | |
| Email | … | | | |
| Date of Blood Draw | … | | | |

|  |  |
| --- | --- |
| **Referring Physician / Nurse** | |
| Last Name + First Name | … |
| Telephone | … |
| Email | … |

|  |  |  |
| --- | --- | --- |
| **Consent** |  | |
| We agree that GENDIA organises the STID, and understand the possibilities and limitations of the STID-test. | | |
| Signature Mother | | Signature Father |
|  | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Payment** | | | | |
| By wire transfer |  | *GENDIA will send you an invoice after registration of the sample.* | | |
| By Master / Visa card |  | Name mentioned on credit card | … | |
| Number | … | |
| Expiration Date | Month: … | Year: … |

|  |
| --- |
| **Genetic Diseases** |
| Are there genetic diseases in the family of the mother of father ? |
| Down Syndrome |
| … |
| Chromosme anomalies |
| … |
| Neural tube defects – spina bifida |
| … |
| Epilepsy |
| … |
| Mental retardation |
| … |
| Deafness before the age of 50 |
| … |
| Blindness before the age of 50 |
| … |
| Cystic fibrosis |
| … |
| Hemophilia |
| … |
| Appearance anomalies (cleft lip and palate) |
| … |
| Congenital anomalies (heart malformations) |
| … |
| Muscle diseases (Duchenne) |
| … |
| Colorectal cancer |
| … |
| Breast or ovarian cancer |
| … |
| Others |
| … |