



# STID

## Screening Test for Inherited Diseases

Patient Identification (Please fill out in CAPITAL letters)			
Family Name Father	...		
First Name Father	...		
Date of Birth Father	...		
Ethnic Origin Father ( <i>the country from where your parents and grandparents originate</i> )	...		
Family Name Mother	...		
First Name Mother	...		
Date of Birth Mother	...		
Ethnic Origin Mother ( <i>the country from where your parents and grandparents originate</i> )	...		
Pregnancy ?	<input type="checkbox"/>	Yes Weeks	<input type="checkbox"/> No
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	<input type="checkbox"/>	<i>GENDIA will send you an invoice after registration of the sample.</i>	
By Master / Visa card	<input type="checkbox"/>	Name mentioned on credit card	...
		Number	...
		Expiration Date	Month: ...    Year: ...



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<b>Genetic Diseases</b>
Are there genetic diseases in the family of the mother or father ?
Down Syndrome
...
Chromosome 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
...