PRONTO DIAGNOSTICS

Test Order Form

Patient's Name		**Referring Center**	
Patient's ID		**Referring Doctor**	
Date of Birth		**Doctor's E-mail**	
Gender	☐ F / ☐ M	**Mailing Address**	
Country		**Phone**	
Sample Type	☐ DNA / ☐ Blood / ☐ Saliva	**Fax**	
Sample Ref. Number		**Comments**	
Date Collected	Day / Month / Year		
Date Sent	Day / Month / Year		

Test Required:

Gene Name		**Sequencing**	☐ Full sequence ☐ Select exons:
RefSeq No.		**MLPA (del/dup)**	
Disease Name		**Point Mutation**	
If urgent, explain		**Other**	

Billing Information: Amount: _________ Euro

Payment Method	☐ Visa ☐ MasterCard ☐ AMEX ☐ Bank Transfer	**Card Holder's Name**	
Credit Card Number		**Billing Address**	
Expiration Date		**Phone**	
CVV2 Number		**E-mail Address**	

Informed Consent:

1. I agree to undergo genetic testing to determine my status in the above-marked gene and I hereby confirm that I was properly and fully informed by the referring doctor specified above regarding the purposes and the nature of the testing, as well as the implications of its results for me and my family, and my rights in connection with such testing.
2. I allow Pronto Diagnostics Ltd. to make anonymous use of the DNA extracted from my saliva/blood sample for research and quality control purposes only. **Yes** ☐ **/ No** ☐ (Please check the appropriate box.).
3. **Sample Requirements:**
   - 200 µL DNA (at a concentration of 50 ng/µL) OR 2 tubes containing 3 mL Peripheral Blood (EDTA tube) OR Saliva collected using the Oragene OG-510 / ON-500 (DNA Genotek) kit.
   - Transport: Room temperature, 20-25°C (68-77°F), 3-5 days. Please send blood samples together with an ice pack. **Do not freeze.**
   - Please ensure that all tubes are properly closed and that all samples are correctly labelled.

   I agree that Pronto Diagnostics Ltd. shall not bear any responsibility or liability whatsoever in connection with the testing and the results thereof, or if the sample is not sent under the conditions specified above, or is damaged in transit, or otherwise.
4. I hereby instruct you to send the results of the testing to the referring doctor specified above and I confirm that I have been informed that such results should be communicated to me with appropriate genetic counseling.

Patient's signature to informed consent and payment ……………………………………. Date ……………………………………..

I hereby confirm that the patient specified above has been referred to you for genetic testing in full compliance with all applicable laws and regulations, and I undertake to fully comply with such laws and regulation in connection with the testing and the results thereof.

Doctor's signature ……………………………………. Date ……………………………………..