Rodinia®
infertility test

男性不妊症パネル
SAMPLE(記入見本)

AFFIX
BARCODE LABEL – SIF
HERE

SAMPLE INFORMATION FORM

※ 必ず、英語で記入をしてください

Please complete sections below in English.

PATIENT INFORMATION

FIRST NAME	Haru	LAST NAME	Yamada
DATE OF BIRTH	31/05/1994	PATIENT GENETIC SEX	Male
PHONE NUMBER	090 1234 5678	EMAIL	haruyamada3105@gmail.com
ETHNICITY	Japanese	SAMPLE COLLECTION DATE	30/07/2023
ADDRESS	Nishi-Kanda 1-3-6		
CITY	Tokyo, Chiyoda-ku	POST CODE	101-0065
COUNTRY	Japan		

ORDERING HEALTHCARE PROVIDER INFORMATION

CLINIC NAME	Hiro Clinic / HUMEDIT	CLINIC ID	
REFERRING HEALTHCARE PROVIDER	HUMEDIT		
PHONE NUMBER		FAX	
EMAIL	info-hi@humedit.co.jp		
ADDRESS			
CITY		POST CODE	
COUNTRY	Japan		

PARTNER TESTING

IS THE PATIENT'S PARTNER HAVING THE RODINIA TEST AS WELL?

☐ YES FIRST AND LAST NAME: DATE OF BIRTH:

☑ NO

COMMENTS:

REQUESTED TEST

Panel options are available below. For more details regarding the genes tested, please refer to Tables on pages 3 & 4.

☐ FEMALE INFERTILITY PANEL	*(55 genes)*
☐ THROMBOPHILIA AND NAIT PANEL ADD-ON TO FEMALE INFERTILITY PANEL	*(22 genetic variants)*
☑ MALE INFERTILITY PANEL	*(40 genes)*
☐ THROMBOPHILIA AND NAIT PANEL ADD-ON TO MALE INFERTILITY PANEL	*(22 genetic variants)*
☐ THROMBOPHILIA AND NAIT PANEL STAND-ALONE PANEL	*(22 genetic variants)*

TEST INDICATIONS

FAMILY HISTORY
(Please specify)

MEDICAL HISTORY
(Please specify any underlying medical condition, including polycystic ovary syndrome, erectile dysfunction, thrombotic events, miscarriages etc.)

SYMPTOMS
(Please specify all symptoms, including pain during intercourse, irregular menstrual cycle, irregular ejaculation, thrombotic events, thrombocytopenia, recurrent miscarriages etc.)

BIOCHEMICAL TEST RESULTS
(Please specify test, specimen and results)

OTHER
(Please specify)

If applicable, please attach detailed medical records and clinical information

FOR LABORATORY USE ONLY
F-OPR-01/16-V7-EN

ORDER NUMBER	LAB ID NUMBER	KIT LOT NUMBER
COMMENTS	DATE & TIME OF RECEIPT (DD/MM/YY HH:NM)	RECEIVED BY

RESTRICTED

MEDICOVER GENETICS
Neas Engomis 31, Nicosia, 2409 Cyprus
Phone: +357 22266888 Fax: +357 22266899
Web: www.medicover-genetics.com
Email: info.genetics@medicover.com

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PATIENT CONSENT

By placing my signature below I hereby:

1. Confirm that I have read, or have had read to me, the attached Patient Informed Consent and that I understand it.
2. Declare that I have had the opportunity to receive counselling from referring healthcare provider on the Rodinia test and to discuss with the healthcare provider all aspects of the Rodinia test and this form including the benefits, risks and limitations of the Rodinia test, as well as the reasons for performing the test and availability of alternative testing options to my satisfaction.
3. Authorize my referring healthcare provider to collect the necessary buccal swab sample, and to submit this form and transport the samples to Medicover Genetics laboratories for the purposes of conducting the tests requested with this form.
4. Authorize Medicover Genetics to use part or the entirety of the biological sample for the purposes of conducting the tests requested with this form.
5. Authorize Medicover Genetics to communicate the results of the test to my referring healthcare provider.
6. Confirm that all the information on this form is true to the best of my knowledge.

Your test results and any unused biological material can help Medicover Genetics improve and further develop the quality, accuracy and effectiveness of diagnosis and help us expand the scope of genetic testing. For this reason, Medicover Genetics would like to use your anonymized, de-identified (i.e. after removing all the personal information from which you can be identified) test results and unused biological material.

☑ For the above scope, I consent to the inclusion of my test results in Medicover Genetics' database, the coding, storing and using of biological material.

PATIENT/GUARDIAN SIGNATURE	DATE
Haru Yamada	30/07/2023

HEALTHCARE PROVIDER ATTESTATION

I hereby certify and undertake that:

1. I am the referring healthcare professional ordering this test.
2. The test results will determine my patient's medical management and treatment options.
3. The patient has been informed about the nature and purpose of the testing.
4. The patient has been duly and thoroughly counseled about the test and has received all the advice necessary to provide their informed consent, including the benefits, risks, and limitations of the Rodinia test.
5. I have answered all the patient's queries about the Rodinia test.
6. This form has been completed according to the wishes and instructions of the patient.
7. I have obtained the patient's informed consent and have attested their signature.

HEALTHCARE PROVIDER SIGNATURE	DATE

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