Adventia®
carrier screening

SAMPLE(記入見本)

AFFIX BARCODE LABEL – SIF HERE

SAMPLE INFORMATION FORM

Please complete sections below in English.

PATIENT INFORMATION

FIRST NAME	Hanako	LAST NAME	Yamada
DATE OF BIRTH	31/05/1994	PATIENT GENETIC SEX	Female
PHONE NUMBER	090 1234 5678	EMAIL	hanakoyamada3105@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	CLINIC ID	
REFERRING HEALTHCARE PROVIDER	Hiro Clinic		
PHONE NUMBER		FAX	
EMAIL			
ADDRESS			
CITY		POST CODE	
COUNTRY	Japan		

PARTNER TESTING

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

- [x] YES
- [ ] NO

FIRST AND LAST NAME: Haru Yamada

DATE OF BIRTH: 30/07/2023

COMMENTS:

REQUESTED TEST

Panel options are available below. Please select one.

FOCUS PANELS

- [ ] **A-Thalassemia** HBA1, HBA2
- [ ] **B-Haemoglobinopathies** (Beta-Thalassemia, Sickle-Cell Disease) HBB
- [ ] **Cystic Fibrosis** CFTR
- [ ] **Duchenne Muscular Dystrophy & Becker Muscular Dystrophy** DMD
- [ ] **Fragile X Syndrome** FMR1
- [ ] **Spinal Muscular Atrophy** SMN1, SMN2

CORE PANEL

- [ ] Alpha Thalassemia; HBA1, HBA2 • Beta Thalassemia; HBB • Becker Muscular Dystrophy; X-linked, DMD • Bloom Syndrome; BLM • Canavan Disease; ASPA • Cystic Fibrosis; CFTR • Duchenne Muscular Dystrophy; X-linked, DMD • Familial Dysautonomia; ELP1 • Fanconi Anemia, Type C; FANCC • Fragile X Syndrome; X-linked, FMR1 • Galactosemia; GALT • Gaucher Disease; GBA • Medium Chain Acyl-CoA Dehydrogenase Deficiency; ACADM • Mucolipidosis Type IV; MCOLN1 • Niemann-Pick Disease, Types A/B; SMPD1 • Non-Syndromic Hearing Loss GJB2-Related and GJB6-Related; GJB2, GJB6 • Phenylalaline Hydroxylase Deficiency (Phenylketonurea); PAH • Sickle-Cell Disease; HBB • Spinal Muscular Atrophy; SMN1, SMN2 • Smith-Lemli-Opitz syndrome; DHCR7 • Tay-Sachs Disease; HEXA

COMPREHENSIVE PANEL

- [x] 231 genes

Includes all genes of the Core panel. For the complete list of genes tested, please visit www.medicover-genetics.com

TEST INDICATIONS

[x] PREGNANCY TESTING	[ ] FAMILY HISTORY (Please specify):	
[ ] CONSANGUINITY	[ ] HIGH RISK ETHNICITY	[ ] CARRIER PARTNER
[ ] EGG/SPERM DONOR	[ ] OTHER (Please specify):	

COMMENTS:

FOR LABORATORY USE ONLY
F-OPR-01/06-V7-EN

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

Adventia®
carrier screening

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 my referring healthcare provider on the Adventia test and to discuss with the healthcare provider all aspects of the Adventia test and this form including the benefits, risks and limitations of the Adventia 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 biological 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
山田花子	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 Adventia test.
5. I have answered all the patient's queries about the Adventia test.
6. This form has been completed according to the wishes and instructions of the patients.
7. I have obtained the patient's informed consent and have attested their signature.

HEALTHCARE PROVIDER SIGNATURE	DATE

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