diagnosticum
Labormedizin • Mikrobiologie
Pathologie • Humangenetik

Health insurance fund(s) or funding institution(s)		
Last name, first name of insured person		Date of birth
Heath insurance fund ID	Insured person's ID	Status
Business establishment ID	Physician's ID	Date

Patient's gender:

Patient Consent for Genetic Testing in accordance with the German Genetic Diagnostics Act (Gendiagnostikgesetz, GenDG)

Stamp of Responsible Medical Professional

Requested Test:

Medical Questions and Clinical Information

MVZ diagnosticum Frankfurt, Center for Human Genetics, investigates all known genes related to any genetic inquiry. You should describe the clinical situation, and we will perform the relevant analysis accordingly. If you have any questions, please contact: **069 - 530 84 370** or **info@genetik.diagnosticum.eu.**

Diagnosis/Suspected Condition:

Symptoms/Medication:

History/Family History:

☐ **The proband/patient is affected** ☐ **Relatives are affected by:**

☐ **Previous findings available – if yes, please attach**

In case of suspected hereditary breast/ovarian cancer: q.v. https://www.ago-online.de/leitlinien-empfehlungen/leitlinien-empfehlungen/kommission-mamma ☐ **Indication criteria fulfilled**

In case of suspected hereditary colorectal cancer: q.v. https://www.leitlinienprogramm-onkologie.de/leitlinien/kolorektales-karzinom ☐ **Indication criteria fulfilled**

Information and Consent for Genetic Testing According to GenDG

By signing below, I agree that the above-mentioned test may be performed to clarify the above indication/diagnosis/suspected condition, and that a sample necessary for this purpose may be collected from me. I have been informed in advance by my physician about:

- the purpose, nature, scope, diagnostic value, and consequences of the genetic testing;
- the health risks associated with sample collection or with knowledge of the results;
- my rights to withdraw consent and to remain unaware of the results (right not to be informed).

in accordance with § 8 GenDG.

I agree to (if not applicable, please cross out):

The test results may be stored longer than the legally required period of 10 years (e.g., for family investigations).

I consent to the use of anonymized test material for scientific purposes.

The American College of Medical Genetics and Genomics (ACMG) recommends that, in addition to answering the primary question, findings related to specific gene variants associated with certain diseases should also be reported. These are gene alterations where knowledge of them can lead to improved and earlier treatment options, providing particular benefit to the individual tested. I wish to be informed about such incidental findings.

My test results will be forwarded to the physicians specified in the order.

Note: As part of genetic counseling according to §10 GenDG, the laboratory may communicate the test results directly to the patient.

State: 06/2025 (B)

Furthermore, I authorize MVZ diagnosticum GmbH to transmit the test results for the purpose of further treatment or follow-up care to the practice/hospital:

practice/hospital, address, ZIP code, city

Location, Date

Location, Date

X

Patient's or Legal Representative's Signature

X

Signature of Responsible Medical Professional