LABOR RENNER

GENE TEST REQUEST FORM

Specimen: **2 - 5 ml Blut (lavender tube)**

Send to: **Labor Renner, Schaftal 50, 8044 Kainbach bei Graz, AUSTRIA**

Coagulation disorders:

- ☐ Factor V Leiden
- ☐ Prothrombin 20210G>A
- ☐ Factor XIII V34L
- ☐ Fibrinogen gamma 10034C>T
- ☐ PAI1 4G/5G
- ☐ Hyperhomocysteinemia (MTHFR)

Metabolic disorders:

- ☐ Hered. hemochromatosis (HFE)
- ☐ Lactose intolerance (LCT)
- ☐ Hereditary fructose intolerance (ALDOB A149P, A174D, N334K)
- ☐ Hereditary fructose intolerance (ALDOB, sequencing of whole gene)
- ☐ α1-antitrypsin deficiency (SERPINA1)

Lipid disorders:

- ☐ ApoB-100 R3500Q
- ☐ ApoE subtypes:
- ☐ Statin side-effects (SLCO1B1)

Osteoporosis:

- ☐ Collagen 1A1 (COLIA1 Sp1)
- ☐ Lactose intoleranz (LCT)

Pharmacogenetics:

- ☐ 5-FU toxicity (DPYD)
- ☐ Thiopurin toxizity (TPMT)
- ☐ Warfarin sensitivität (VKORC1, CYP2C9)
- ☐ CYP2C9
- ☐ Clopidogrel resistance (CYP2C19)
- ☐ Statin side-effects (SLCO1B1)
- ☐ Methotrexate toxizität (MTHFR)

Autoimmune diseases:

- ☐ HLA-B*27
- ☐ Zöliakie (HLA-DQA1, -DQB1)

Miscellaneous:

- ☐ Age-related macular degeneration (CFH)
- ☐ Fam. mediterranean fever (MEFV)
- ☐ .....

Patient: Full name: .....

Date of birth: .....

Invoice to: ☐ Patient - Adress: .....

.....

☐ Requesting hospital / laboratory

☐ Requesting Physician

..... (Date) ..... (Name of requesting physician, PLEASE PRINT) ..... (Signature of requesting physician)

Informed consent

I have been informed by the requesting physician on the principles, purpose and scope of the requested gene test and do hereby consent to provide a specimen for testing.

..... (Date) ..... (Signature of patient)

A201209

Laboratory for Molecular Genetics
Univ.-Doz. Prof. Dr. Wilfried Renner
Schaftal 50
8044 Kainbach bei Graz
Tel +43 (0) 664 124 2483
Fax +43 (0) 316 231123 7030
www.labor-renner.at
office@labor-renner.at