Patient data / Stickers

_____
Surname, First name

_____
Date of birth

_____
Street

_____
Post code, Place

Declaration of consent for genetic testing according to the Gene Diagnostics Act (GenDG)

The fully completed and signed declaration of consent of the patient or his/her legal representative is an absolute prerequisite for carrying out the genetic examination.

Clinical symptoms / suspected diagnosis / indication / question

Please delete as appropriate:

I agree with the required collection of sample material and the genetic investigation related to the clinical symptoms / suspected diagnosis / indication / question.

If necessary, I agree with the transfer of the investigation results and the collected data to a specialized Institution.

Depending on the study and in order to achieve high sensitivity, a comprehensive DNA examination may be required.

In the context of genetic analyzes, information can be obtained which are not related to the study, but may nevertheless be of medical importance to me or my relatives (incidental or additional findings).

In this case, I want to be informed about additional findings: □ yes □ no

(If no explicit selection is made, "No, I do not want to be informed about additional findings" should take place)

I am aware that I have no claim to completeness or future update of such additional findings.

I was informed that due to the requirements of health insurance companies, previously not described DNA variants are documented in publicly accessible databases.

I agree that surplus research material and the collected data will be used in encrypted (pseudonymised) form to investigate the causes and improve the treatment of genetic disorders and to publish results in scientific journals. For this I give my permission to use the material / data by the Division of Translational Oncology, Department of Internal Medicine II, Tübingen.

I agree with the storage of test results and documents beyond the prescribed period of 10 years.

I agree with the storage of study material for the purpose of verification of the results and for usage of new diagnostic options in the future.

If necessary, the results of the investigation may be used for counseling and investigation of family members.

I agree with passing on of the findings to the attending physicians and to the International Registry of Severe Chronic Neutropenia (SCNIR).
(If you do not agree to a transfer to the SCNIR, please delete the passage).

Additions:

I was informed in a personal interview by my attending physician about the significance and implications of the diagnosis and especially about the purpose, nature, extent, significance and consequences of the examinations. I had the necessary thinking time. I can withdraw this consent at any time in whole or in part.

…….	…….	……	……
Place, Date	Signature patient / legal representative *	Signature enlightening doctor	Stamp of the enlightening doctor (Printed Name)

(*In the case of children, both parents must consent and sign, or a power of attorney must be present if not all guardians are present.)

Sample submission:
Medical Clinic, Division II
Prof. Julia Skokowa
Otfried-Müller-Str. 10, 72076 Tübingen

Questions to:
Phone: 07071/29-86013