



GENDIA
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SAMPLE SUBMISSION FORM TO BE FILLED OUT BY REQUESTING PHYSICIAN/LAB

PATIENT IDENTIFICATION **REQUESTING PHYSICIAN / LAB**

Last Name:	Last Name:			
First Name:	First Name:			
Gender: <table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 50%;">Male <input type="checkbox"/></td> <td style="text-align: center; width: 50%;">Female <input type="checkbox"/></td> </tr> </table>	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Lab/Hospital Name:	
Male <input type="checkbox"/>	Female <input type="checkbox"/>			
Date of birth: <table style="width: 100%; border: none;"> <tr> <td style="border-top: 1px dashed black; width: 33%; text-align: center;">Day</td> <td style="border-top: 1px dashed black; width: 33%; text-align: center;">Month</td> <td style="border-top: 1px dashed black; width: 33%; text-align: center;">Year</td> </tr> </table>	Day	Month	Year	Adress:
Day	Month	Year		
Ethnic origin:				
Country:	Country:			

SAMPLE INFORMATION **METHOD OF PAYMENT**

Type: <table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 33%;">DNA <input type="checkbox"/></td> <td style="text-align: center; width: 33%;">Whole Blood <input type="checkbox"/></td> <td style="text-align: center; width: 33%;">Serum <input type="checkbox"/></td> </tr> </table>	DNA <input type="checkbox"/>	Whole Blood <input type="checkbox"/>	Serum <input type="checkbox"/>	Phone:
DNA <input type="checkbox"/>	Whole Blood <input type="checkbox"/>	Serum <input type="checkbox"/>		
Sample Number/Code:	Fax:			
Date of Collection: <table style="width: 100%; border: none;"> <tr> <td style="border-top: 1px dashed black; width: 33%; text-align: center;">Day</td> <td style="border-top: 1px dashed black; width: 33%; text-align: center;">Month</td> <td style="border-top: 1px dashed black; width: 33%; text-align: center;">Year</td> </tr> </table>	Day	Month	Year	E-mail:
Day	Month	Year		
Date Sent: <table style="width: 100%; border: none;"> <tr> <td style="border-top: 1px dashed black; width: 33%; text-align: center;">Day</td> <td style="border-top: 1px dashed black; width: 33%; text-align: center;">Month</td> <td style="border-top: 1px dashed black; width: 33%; text-align: center;">Year</td> </tr> </table>	Day	Month	Year	I agree with the GENDIA's general Terms and Conditions and confirm to pay promptly the GENDIA invoice, which will be issued after testing is completed.
Day	Month	Year		

TEST REQUIRED **INVOICING INFORMATION**

Gene Name:	Signature:			
Gene OMIM Number: (enter if applicable)	Date: <table style="width: 100%; border: none;"> <tr> <td style="border-top: 1px dashed black; width: 33%; text-align: center;">Day</td> <td style="border-top: 1px dashed black; width: 33%; text-align: center;">Month</td> <td style="border-top: 1px dashed black; width: 33%; text-align: center;">Year</td> </tr> </table>	Day	Month	Year
Day	Month	Year		
Other Test(s)	Settlement: <table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 33%;">Visa <input type="checkbox"/></td> <td style="text-align: center; width: 33%;">MasterCard <input type="checkbox"/></td> <td style="text-align: center; width: 33%;">Bank Transfer <input type="checkbox"/></td> </tr> </table>	Visa <input type="checkbox"/>	MasterCard <input type="checkbox"/>	Bank Transfer <input type="checkbox"/>
Visa <input type="checkbox"/>	MasterCard <input type="checkbox"/>	Bank Transfer <input type="checkbox"/>		
Disease Name:	INVOICING INFORMATION (Only fill out when different from "Requesting Physician / Lab")			
Disease OMIM Number: (enter if applicable)	Name:			
If test is urgent explain:	Address:			
	VAT number: <i>(if applicable)</i>			
	Phone:			
	E-mail:			

RELEVANT CLINICAL INFORMATION **CREDIT CARD INFORMATION**

	Name on Credit Card:
	Credit Card Number:
	Expiration Date: