



**GENDIA**  
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## SAMPLE SUBMISSION FORM

TO BE FILLED OUT BY REQUESTING PHYSICIAN/LAB

### PATIENT IDENTIFICATION

### REQUESTING PHYSICIAN / LAB

Last Name:			
First Name:			
Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	
Date of birth:	Day	Month	Year
Ethnic origin:			
Country:			

Last Name:	
First Name:	
Lab/Hospital Name:	
Adress:	
Country:	

### SAMPLE INFORMATION

Type:	DNA <input type="checkbox"/>	Whole Blood <input type="checkbox"/>	Serum <input type="checkbox"/>
Sample Number/Code:			
Date of Collection:	Day	Month	Year
Date Sent:	Day	Month	Year

Phone:	
Fax:	
E-mail:	

### METHOD OF PAYMENT

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.

### TEST REQUIRED

Gene Name:	
Gene OMIM Number: (enter if applicable)	
Other Test(s)	
Disease Name:	
Disease OMIM Number: (enter if applicable)	
If test is urgent explain:	

Signature:			
Date:	Day	Month	Year
Settlement:	Visa <input type="checkbox"/>	MasterCard <input type="checkbox"/>	Bank Transfer <input type="checkbox"/>

### INVOICING INFORMATION

*(Only fill out when different from "Requesting Physician / Lab")*

Name:	
Address:	
VAT number: (if applicable)	
Phone:	
E-mail:	

### RELEVANT CLINICAL INFORMATION

### CREDIT CARD INFORMATION


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