Institut für Immunologie und Transfusionsmedizin
Abteilung Transfusionsmedizin
Leiter: Prof. Dr. med. A. Greinacher

Thrombozytenlabor
F.-Sauerbruch-Str.
17475 Greifswald
Tel.: 0049-3834/865475
Fax: 0049-3834/865547

(12.04.2016)

Universitätsmedizin GREIFSWALD

Patient information	**Submitted by**
Last name / First name	Name
Date of birth (dd/mm/yyyy) / ☐ male ☐ female	Address:
Address (Street)	
Zip code / city / State/country	Signature / Date:

Billing address

Name and address of institution

Inherited platelet disorders

15 air-dried unstained blood smears, 2 stained blood smears, 5-10 ml EDTA-blood; (3-5 ml EDTA-blood, children)

☐	**Screening**	
	☐ thrombocytopenia ☐ platelet function disorder	
☐	**special examination**	
		Genetic testing requires consent of the patient !
	☐ MYH9-related disease	☐ genetic testing requested
	☐ Bernard-Soulier syndrome	☐ genetic testing requested
	☐ von Willebrand Typ IIb (+ 3ml citrated blood)	☐ genetic testing requested
	☐ GATA 1 Mutation	☐ genetic testing requested
	☐ Storage pool disease	☐ genetic testing requested
	☐ Glanzmann thrombasthenia	☐ genetic testing requested
☐	**others:**	

Bleeding tendency	please describe (e.g. easy bruising, menorrhagia, joint bleeding, etc.)
☐ mild ☐ intermediate ☐ severe	

If family history of relatives is positive:

- Mutation ☐ known, please specify: ________________________________
  ☐ unknown

☐ Consanguinity

☐ More than one generation affected

- pedigree

Ethnicity of the patient:

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Consent form of the patient/ legal guardian	
I have been informed about the purpose of this genetic test by my physician Dr.______________. I have received full information by my physician concerning the suspected diagnosis of a platelet disorder, its genetic basis, the possible interpretation, and limitations of the diagnostic testing.	☐ yes ☐ no
Results of the genetic diagnostic testing for platelet disorders may be disclosed to the following physicians: Dr. M. Baschin/Prof. Dr. A. Greichacher (platelet lab Greifswald) and	
I understand that my results may enable other family members to benefit from genetic testing. I confirm my consent that genetic information about my platelet disorder which may be relevant for other family members will be disclosed to their treating physician.	☐ yes ☐ no
According to German legal regulations I agree that the laboratory results of this examinations will not be destroyed after 10 years and can be made available to members of my family after my death, if needed by their treating physician. After completion of the analysis, I assign all remaining examination materials to the laboratory that carried out the analysis, according to § 950 BGB (= German Civil Code/Law). I consent that genetic test results will be retrained after this time in accordance with privacy protection provisions for the genetic counselling and testing of further family members.	☐ yes ☐ no
I appreciate that the sample may be sent to another laboratory for testing. I understand that, in developing and standardising new tests, it may be necessary to use part of the sample anonymously.	☐ yes ☐ no
I give my consent to the storage of my blood sample, data on paper as well as on electronic media according to the legal requirements. This means that only the physicians and technologists of laboratory in Greifswald will know my identity. I also give my consent to the possible publication of my data for scientific purposes in a way where the patient identifiers are kept confidential. This means that all efforts are made to avoid identification of my personality. Neither my name, nor other personal data will be published.	☐ yes ☐ no
Additionally, I give my consent to the transfer of my data – if necessary - to a billing agency for physicians for the purpose of issuing an invoice.	☐ yes ☐ no

I am free to withdraw any of the above statements in writing without reasons at any time.

I have no further questions about DNA testing. I have been informed about the genetic testing and all questions were fully answered by my physician in person.

______________________________ ______________________________

place, date Signature (patient / legal guardian)

Please take care completing this application in full. Answer all the questions!

Contact person:
Thrombozytenlabor: Prof. A. Greinacher (Thrombozytenlabor: 0049-3834 – 865475)

Genetic testing will be performed in the Institute of Human genetics of the University of Greifswald:

Institut für Humangenetik
Direktorin: Prof. Dr. med. Ute Felbor

Molekulargenetik
Fleischmannstraße 42/44
17475 Greifswald
Tel.: (0049-3834) 865375;
Fax: (0049-3834) 865393

Contact person: Dr. rer. nat. J. Najm (Telefon: 0049-3834 - 865375)