Cerba

MEDICAL PRESCRIPTION FORM

CONSULTATION CERTIFICATE / CONSENT TESTING

Laboratoire Cerba
Customer relation service
Tel.: +33 (0)1 34 40 97 76
Fax: +33 (0)1 34 40 21 29
Email: intgb@lab-cerba.com

HAEMOGLOBIN ANALYSIS

For molecular analysis of globin genes:
Mandatory completion of the signed consultation certificate and consent form (document overleaf)

TESTING LABORATORY

Customer n°: |_|_|_|_|_| C /|_|

Mandatory Stamp

SAMPLING

Sampling date |_|_|/|_|_|/|_|_|_|_|

Sampling date:

2x5mL EDTA whole blood
shipped at room temperature and performed xithin 7 days

PATIENT

Surname .....

First name .....

Maiden name .....

Address .....

CP ..... City .....

Date of birth: |_|_|/|_|_|/|_|_|_|_|

Geographical origin:

☐ Europe ☐ North Africa ☐ Sub-Saharan Africa

☐ Reunion Island ☐ Antilles, Guyana ☐ Asia

☐ Other: .....

PRESCRIBER

Surname .....

First name .....

Maiden name .....

Address .....

CP ..... City .....

Tel. |_|_| |_|_| |_|_| |_|_| |_|_|

Fax |_|_| |_|_| |_|_| |_|_| |_|_|

E-mail address: .....

Signature:

INDICATION

☐ **Population at risk**
Pregnancy, family history, geographical origin, anaemia...

☐ **Etiological assessment of unexplained microcytosis and/or polycythemia**

☐ **Haemoglobin abnormality by HPLC/Electrophoresis**
Attach a copy of results

☐ **HbA1c result not measurable**
Attach a copy of results

☐ **Genetic study in a couple at risk for prenatal diagnosis**

REQUESTED TEST

☐ **Haemoglobin HPLC/Electrophoresis study** (*EPHB*)
Attach a copy of the results of the CBC blood count

☐ **Molecular analysis of globin genes*:**

- ☐ *HBB* gene (S and/or C variants only) (*DREP*)
- ☐ *HBB* gene (complete study beta-thalassaemia +/- S/C) (*HBETA*)
- ☐ *HBB*, *HBA1* and *HBA2* genes (full study: variant X) (*VAHB*)
- ☐ *HBA1* and *HBA2* genes (alpha-thalassemia) (*49528*) (external shipment)

*consultation certificate and consent form (overleaf) must be completed and signed

SUPPORT INFORMATION

- Has patient been transfused over the last three months: ☐ No ☐ Yes, date : |_|_|/|_|_|/|_|_|_|_|
- Has an iron assessment been performed: ☐ No ☐ Yes

If yes, is it: ☐ Normal ☐ Pathological *(specify)*: .....

Cerba Laboratory is responsible for processing your personal data provided in this form as the data controller, in order to perform tests, interpret them, transmit results, and manage the laboratory's administrative tasks. If you are a patient, your data may then be reused for anonymization purposes for scientific research, quality control, statistical studies, or satisfaction surveys. To learn more about how your personal data is processed, your rights, and research projects based on your data, visit the website www.lab-cerba.com, under the "Personal Data" and "Research Projects" tabs. To exercise your rights of opposition, contact our Data Protection Officer (DPO) at: rpd.cerba@labcerba.com / CERBA–RPD – ZAC DES EPINEAUX 10-12 Avenue ROLAND MORENO CS 51312 95740 FREPILLON. / If you are a patient, in accordance with applicable regulations, once your tests are completed, any remaining samples from your tests will be disposed of. However, they may be kept for use in scientific research or quality control purposes, either directly or after transfer to third parties, in strict compliance with medical confidentiality. You may object to such use by simply making a request to our DPO (contact details above).

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DECLARATION OF CONSULTATION BY THE PRESCRIBING PHYSICIAN OR GENETIC COUNSELLOR

I hereby certify that I have informed the above-mentioned patient, as well as his/her parents (legal representatives), about the characteristics of the disease being researched, the means of diagnosing it, the possibilities for prevention and treatment, and the storage of his/her sample. I also certify that I have obtained the consent of the patient AND that of his/her legal guardian in accordance with the conditions outlined in the French Public Health Code (Articles R1131-4 and 5).

PATIENT	LEGAL GUARDIAN	PRESCRIBER
Surname: *First name:* *Date of birth:*	*Surname, First name, Date of birth:* If the patient is a minor or an adult under guardianship, relationship to the patient:	*Surname:* *First name:*
Signature	*Signature*	*Signature*

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION AND CONSENT FOR THE TEST(S) TO BE CARRIED OUT

I, the undersigned, certify that I have received from:

☐ the medical geneticist: Dr/Pr……

☐ a genetic counsellor under the supervision of Dr/Pr……..……..

Information concerning the above recommended genetic test(s), which will be carried out on the basis of:

☐ biological specimen(s) I have auto-sampled

☐ biological sampling on my child or on an adult under my guardianship

And I consent to genetic testing in the context of:

I have been informed:

- Of my right to request (at any time): that this study be interrupted; that the results be withheld from me; and/or that my stored samples be destroyed.
- That the complete interpretation of these results relies, in certain situations, on the definition of biological kinship, which can be analysed using these samples.
- Of my duty to inform family members in the event of the identification of any serious genetic abnormality, warranting preventive measures (including genetic counselling or treatment).

I will receive the results of these tests, and the prescribing physician (or genetic counsellor) will explain them to me, based on the current state of knowledge in genetic counselling.

I consent to have my biological sample stored and subsequently used to continue investigations within the scope of this diagnostic approach, according to the progression of knowledge.	☐ Yes ☐ No
The technique employed may reveal genetic information that is unrelated to the pathology in question: such a discovery may have an impact on my health or the health of my relatives. I would like to be informed of such results.	☐ Yes ☐ No
I consent to have my sample and all necessary medical data, including photographs, transferred to another laboratory to complete this genetic study.	☐ Yes ☐ No
I consent to the recording and storage of medical data useful for diagnostic management in computer databases.	☐ Yes ☐ No

Part of my sample may remain unused within the context of this diagnostic approach. I consent to its storage and use for internal laboratory quality assurance studies.	☐ Yes ☐ No
I consent to the anonymous use of my medical data and/or a portion of my samples for research projects, without any direct personal benefit.	☐ Yes ☐ No

I was given the opportunity to ask the geneticist or genetic counsellor (who prescribed this analysis) all my questions, and I received complete and satisfactory answers.

Signed in …… on ……

SIGNATURE

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