MEDICAL PRESCRIPTION FORM

CONSULTATION CERTIFICATE / CONSENT FOR TESTING

ASSESSMENT OF THE RISK OF TOXICITY OF FLUOROPYRIMIDES AND IRINOTECAN

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

Complete, date and sign the consultation certificate and consent for all genotyping requests

For phenotyping: 1 tube of 5-7 ml of whole blood in an EDTA or heparin tube **WITHOUT GEL**, decanted and frozen. The maximum time between collection and centrifugation is 1 hour if the sample is stored at room temperature, and 4 hours if stored between +2°C and +8°C, with centrifugation preferably at +4°C. The centrifugation speed is > 15 minutes at 1500 to 2000 g or > 10 minutes at 2000 to 2500 g. Standard **double** centrifugation, with plasma decanting between the two steps (achieving a residual platelet count of < 10 x 10^9/l). Immediate freezing of the obtained plasma, transport must respect the cold chain (strictly frozen). **Mark "URGENT"** on the plastic bag.

Pour un Génotypage : 1 5-7mL EDTA whole blood tube Shipment at room temperature and made within 7 days maximum.

TESTING LABORATORY

N° Client: |_|_|_|_|_| C /|_|

Mandatory Stamp

SAMPLING

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

For phenotyping, the following must be specified:

Sampling time |_|_| h |_|_|

Centrifugation time |_|_| h |_|_|

Freezing time |_|_| h |_|_|

PATIENT

Surname ……

First name……

Maiden name……

Adress ……

City …….. Country ……

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

PRESCRIBER

Surname ……

First name……

Adress ……

City …….. Country ……

Tél. ……..Fax ……

E-mail adress: ……

Signature :

REQUESTED TEST

☐ **DPD PHENOTYPING (plasma uracil)**

Indication :

☐ Before Treatment *(OPL code: DPDFP)*
Screening before initiating fluoropyrimidine therapy

☐ Toxicity – Reintroduction *(OPL code: DPDTX)*

☐ Treatment already initiated *(OPL code: DPDAU)*

☐ **DPYD GENOTYPING** *(OPL code: DPDGE)*
Analysis of the DPYD*2A, D949V and DPYD*13 variants according to recommendations

☐ **UGT1A1 GENOTYPING** *(OPL code: UG1A1)*
Promoter analysis

☐ **DPYD AND DPYS GENOTYPAGING**
Full analysis (coding regions and intron/exon junctions +/-50bp) of the genes

DECLARATION OF CONSULTATION BY THE PRESCRIBING PHYSICIAN OR GENETIC COUNSELLOR
ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION AND CONSENT FOR GENETIC TESTING
to be completed, dated and signed mandatory for Genotyping requests

I, the undersigned, Dr/Pr…….. or Mr/Mrs …… genetic counselor under the supervision of Dr/Pr…….. certify that I have informed the undersigned patient and his/her parents (legal representatives) about the characteristics of the investigated disease or genetic susceptibility to drug treatment, how to diagnose it, how to prevent and treat it, how the disease is transmitted and the possible consequences in other members of the family, the storage of the sample, and that I have obtained the consent of the patient AND his/her guardianship under the conditions provided for by the French public health code (articles R1131-4 and 5).

I, the undersigned, Mr, Mrs……born on ……
Living in: ……

Acknowledge that I have received information on the genetic testing that will be performed to assess my genetic susceptibility to drug treatment from Dr/Pr…….. ……., 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.

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

To this end, I consent: ☐ to the collection of my sample ☐ to the collection of my minor child's sample or an adult under guardianship's sample

☐ I consent to its use, where appropriate, for scientific research purposes. In this case, all my medical data will be protected through total anonymization. Therefore, I am aware that I will not receive any benefit or have any prejudice from these scientific studies.

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

Done in ……, On ……

Laboratoire Cerba, in its capacity as data controller, is required to process the personal data you provide on this form in order to carry out examinations, interpret them, transmit results and for the administrative management of the laboratory. If you are a patient, your data may then be reused for the purposes of anonymization for scientific research, quality control, statistical studies or satisfaction surveys. To find out more about the processing of your personal data, your rights and the research projects carried out using your data, go to www.lab-cerba.com, "Personal Data" and "Research Projects" tabs. To exercise your right to object, contact our RPD at: rpd.cerba@lab-cerba.com / CERBA-RPD - Zac des Epinaux 10-12 Avenue Roland Moreno 95740 Frépillon. / If you are a patient, in accordance with applicable regulations, once your examinations have been completed, the residues from your samples will be disposed of. However, they may be kept for re-use in scientific research or quality control, either directly or after transfer to third parties, in strict compliance with medical confidentiality. You may object to such use by contacting our DPR (see contact details above).