



GENDIA
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SAMPLE SUBMISSION FORM

TO BE FILLED OUT BY REQUESTING PHYSICIAN/LAB

PATIENT INFORMATION

REQUESTING PHYSICIAN / LAB

*** In order to guarantee maximal patient privacy GENDIA only works with patient codes and not with patient names. Please use a CODE (with at least 6 numbers and/or letters) instead of your NAME and keep this code in a safe place, as GENDIA will only use this code in all documents.**

Patient Code*			
Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	
Date of birth:	Day	Month	Year
Country:			

Last Name:	
First Name:	
Lab/Hospital Name:	
Address:	
Country:	
Phone:	
Fax:	
E-mail:	

SAMPLE INFORMATION

Type:	DNA <input type="checkbox"/>	Blood <input type="checkbox"/>	Saliva <input type="checkbox"/>
Date of Collection:	Day	Month	Year
Date Sent:	Day	Month	Year

RELEVANT CLINICAL INFORMATION

TEST REQUIRED

Test:	
Gene OMIM Number: (enter if applicable)	
Disease Name:	
Disease OMIM Number: (enter if applicable)	
If urgent please explain:	

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