Micro Trace Minerals Laboratory

40+ years of clinical & environmental laboratory diagnostics

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Submission Form: GENETIC TESTING

Requesting Clinic/Doctor: _____

New Customer or if contact information has changed, please fill out the fields on page 2.

Patient Name: _____

Street: _____ ZIP: _____ City: _____

State: _____ Country: _____

Phone: _____ Fax: _____

E-mail: _____

please fill out if report is to be mailed to the patient (please complete in block capitals)

Date of Birth: _____ Sex: m f

Order for Genetic Testing:

GSTM1	68.00 €	**GSTT1**	68.00 €	**GSTP1**	68.00 €
CYP1A1	68.00 €	**NAT2**	350.00 €	**SOD1**	68.00 €
SOD2	68.00 €	**ApoE**	78.00 €		

Test material: 1ml EDTA blood or 5 drops of whole blood on filter paper

Send Report to: Doctor Patient both addresses (€ 9,95 surcharge)

Send Report via: Post E-Mail Fax

Payment via: **Invoice to:** Doctor Patient

Credit Card VISA Mastercard Card Number: _____

valid thru (MM/YY): _____ 3-digit code: _____

Bank transfer done at: _____ for €: _____

PayPal **Payment was made to address: service@microtrace.de**

Pre-Payment or Credit Card is Needed, otherwise samples will be held until payment is received.

*** please turn over ***

Declaration of Consent in Accordance with the Gene Diagnostic Act (GenDG)

I herewith agree ,

(Name, first name of the patient in block capitals)

to the testing of genetic tests performed on my sample as requested on the attached remittance sheet.

Furthermore, I agree that for the purpose of laboratory medical diagnostics my sample and personal data may be forwarded to the laboratory performing the tests.

I am aware that laboratory results are only available to the requesting clinician.

[Voluntary addition, please delete if not applicable]: The GenDG asks for the immediate destruction of the sample material after the test. I herewith agree that sample and data are kept for research purposes, incl. the publication of data in anonymized form.

Date: Signature of patient/or legal representative

New Customer or if contact information has changed,	**or**	**Clinic/Doctor Stamp**
Address:		
Phone:		
Fax:		
E-mail:		

Informed consent for data protection

I consent to my sample being collected by the responsible medical practitioner or alternative therapist, and being transmitted to Micro Trace Minerals GmbH ("MTM") for the purpose of possessing and performing the assay I have requested. Furthermore, I agree that MTM will send my sample material, my name and my date of birth to specialist laboratories in Germany for carrying out the test I have requested and that MTM will be notified of the result. If I wish to send MTM's test result to the responsible physician or alternative practitioner, I agree that he/she will view the test result to provide a diagnosis. I may revoke my consent at any time to the responsible physician or alternative practitioner or to Micro Trace Minerals GmbH. Until my consent is effectively revoked, the processing of my personal data will remain legal.

Details can be found in our privacy policy at: https://microtraceminerals.com/en/contact/data-protection/laboratory-order

By signing below, I certify that all information provided is correct.

Date: **Patient Signature:** x

(please do not forget)

Barcode GST Barcode CYP / NAT Barcode SOD / ApoE

This Form can also be filled out on the PC, please visit: https://microtraceminerals.com/en/submission-forms/