**REQUISITION OF POSTNATAL GENETIC STUDIES**

### I. REQUESTING ENTITY

**REQUESTING PHYSICIAN**

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### II. SAMPLE SENT

**COLLECTION DATE**

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### III. CLINICAL INFORMATION

1. **Which of the following hypotheses justified the requisition of the study?**

- [ ] Mental Retardation
- [ ] Dysmorphic / Malformations
- [ ] Genital Ambiguity
- [ ] Growth Retardation / Poor Progression
- [ ] Primary Amenorrhea
- [ ] Secondary Amenorrhea
- [ ] Early Menopause
- [ ] Infertility
- [ ] Couple with Repetitive Abortions
- [ ] Family with Chromosomal Alterations

Please Briefly Describe the Most Relevant Changes:

2. **What is the suspected diagnosis?**

- [ ] Trisomy 21 (Down's Syndrome)
- [ ] Trisomy 18 (Edwards Syndrome)
- [ ] Trisomy 13 (Patau Syndrome)
- [ ] Turner's Syndrome
- [ ] Klinefelter’s Syndrome
- [ ] X-Fragile Syndrome
- [ ] Angelman Syndrome
- [ ] Prader-Willi Syndrome
- [ ] Catch 22 (S. Digeorge, Velocardiofacial)
- [ ] Williams Syndrome
- [ ] Lejeune Syndrome
- [ ] Wolf-Hirschhorn

3. Other Chromosome Anomaly? What?

### IV. INTENDED ANALYSIS (PLEASE MENTION ALL THE EXAMS REQUESTED IN THE TERM OF RESPONSIBILITY)

- [ ] Karyotype
- [ ] Study by FISH for the situation indicated above
- [ ] Array Low Resolution (ACGH)
- [ ] Array High Resolution (SNP Array)
- [ ] Molecular Research of Fragile X
- [ ] Other Study. What?

**INFORMED CONSENT**

I consent to having the above genetic testing performed on which I was previously clarified in a clear and objective way on the application and limitations of the same.

I authorize the collection of the biological sample required to perform the genetic test(s) indicated by the Germano de Sousa Laboratory Medical Center or, where necessary, by other laboratories designated by the same.

I authorize that the data contained in this form are registered and processed only by duly authorized professionals, guaranteeing the protection and confidentiality according to the law in force.

I give my consent for the result(s) to be sent to the prescribing physician.

I have been informed of my right to revoke consent at any time without justification by sending an email.

Signature of the Patient or the Legal Responsible (Minor or Major Incapable): OBLIGATORY

Signature of the Doctor: OBLIGATORY

Contact for Submission of Results: OBLIGATORY

**IMPORTANT:** Send the sample on the day of harvest. Do not send on Friday, not on the eve of holiday (consult central laboratory)