



REQUEST FOR AN EXAMINATION OF GENETIC CHARACTERISTICS

To be completed by the doctor and attached to the sample accompanied by the prescription

<p>IDENTITY OF THE SUBJECT SAMPLED</p> Name: Forename: Date of birth: / / Address: Postcode: Town: Country: If a minor, name of the legal guardian: Name : Forename:	<p>SAMPLING LABORATORY</p> Address: (or seal of the laboratory) Tel. No.: Date of sample: / / Date sent: / /
<p>PRESCRIBING DOCTOR</p> Name: Forename: Address: Tel: Fax: Signature:	<p>DECLARATION BY THE DOCTOR:</p> I hereby certify that I have given the patient the information required under Article R.145-15-5 of Decree No. 2000-570 dated the 23 June 2000 and that I have acquired his consent in accordance with the conditions contained in Article R.145-15-4. Made at: Date: Signature:

EXAMINATION REQUIRED:
Give a clinical report and a genealogical tree in cases where a family study is required

<input type="checkbox"/> Haemochromatosis (C282Y and H63D)	<input type="checkbox"/> Glaucoma: MYOC and/or CYP1B1 and/or OPTN
<input type="checkbox"/> Factor II (G20210A)	<input type="checkbox"/> and/or WDR36
<input type="checkbox"/> Factor V (R506Q)	<input type="checkbox"/> Glaucoma (Polymorphisms MYOC.mt1/APOE)
<input type="checkbox"/> MTHFR (C677T)	<input type="checkbox"/> Retinitis pigmentosa: RPE65 and/or LRAT
<input type="checkbox"/> Sickle cell anemia (E6V)	<input type="checkbox"/> Retinitis pigmentosa (X-linked): RP2and/or RPGR
<input type="checkbox"/> Cystic Fibrosis (Exons 3, 4, 7, 10, 11, 19, 20 et 21)	<input type="checkbox"/> Thalassaemia Beta :
<input type="checkbox"/> Microdeletions of the Yq chromosome (AZFa, AZFb, AZFc)	<input type="checkbox"/> Other: