GC Genome
The Frontier Company in Genomic Diagnostics

General Requisition Form

Barcode

* All reqired fields MUST be filled in.

Patient Information			
*First Name		*Last Name	
*Date of Birth	D D / M M / Y Y Y Y	*Sex	□ M □ F
City / State / Country		*Primary Ethnicity (Choose one)	□ African □ Asian □ Caucasian □ Hispanic □ Others

Physician Information			
*Clinic/Hospital Name		*Department	
*Name		E-mail	

Specimen Information			
*Collection Date	D D / M M / Y Y Y Y	Sample Type	□ EDTA 3ml □ G-card (Blood paper)

Prenatal / Postnatal ScreeningTest * For G-NIPT and i-screen, please use a separate request form.

- ☐ Fragile-X PCR
- ☐ Hearing Loss Gene Screening
- ☐ Wilson Disease Gene Screening
- ☐ Myotonic Dystrophy Type1 Screening

Health Check-up * For greenbiome, please use a separate request form.

Premium Options

- ☐ Genome Screen - Cancer
- ☐ Genome Screen - Sudden Cardiac Arrest
- ☐ Genome Screen - Stroke
- ☐ Genome Screen - Hyperlipidemia

Basic Options

- ☐ Risk Screen - Cancer (M)
- ☐ Risk Screen - Cancer (F)
- ☐ Risk Screen - Stroke
- ☐ Risk Screen – Hyperlipidemia
- ☐ Risk Screen – Eye
- ☐ Risk Screen – Alcohol

Others

- ☐ Pharmacogenetics
- ☐ Telorisk (Telomere test)

※ Please include any additional clinical history.

▪ I consent to providing above described personal information. ☐ Confirmed

▪ I was fully explained and understood the limitations of this test and the confirmations prior to requesting a test, and hereby I request this test. ☐ Confirmed

Date : (Y Y / M M / D D) Name: (Signature)

CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS

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