Ventrilia®
cardiovascular test

SAMPLE(記入見本)

AFFIX
BARCODE LABEL — SIF
HERE

SAMPLE INFORMATION FORM

Please complete sections below in English.

※ 必ず、英語で記入をしてください

PATIENT INFORMATION

FIRST NAME	Hanako	LAST NAME	Yamada
DATE OF BIRTH	31/05/1994	PATIENT GENETIC SEX	Female / Male
PHONE NUMBER	090 1234 5678	EMAIL	hanakoyamada3105@gmail.com
ETHNICITY	Japanese	SAMPLE COLLECTION DATE	30/07/2023
ADDRESS	Nishi-Kanda 1-3-6		
CITY	Tokyo, Chiyoda-ku	POST CODE	101-0065 Japan

ORDERING HEALTHCARE PROVIDER INFORMATION

CLINIC NAME	Hiro Clinic / HUMEDIT	CLINIC ID	
REFERRING HEALTHCARE PROVIDER	HUMEDIT		
PHONE NUMBER		FAX	
EMAIL	info-hi@humedit.co.jp		
ADDRESS			
CITY		POST CODE	Japan

REQUESTED TEST

Panel options are available below

- ☐ **Aortopathy** (48 genes)
- ☑ **Arrhythmia** (42 genes)
- ☐ **Cardiomyopathy** (98 genes)
- ☐ **Congenital Heart Defects** (80 genes)
- ☐ **Familial Hypercholesterolemia** (11 genes)
- ☐ **Pulmonary Hypertension** (11 genes)
- ☐ **RASopathies** (30 genes)
- ☐ **Comprehensive Panel** (292 genes)
  Includes all genes tested in the panels above.

For the complete list of genes tested, please visit www.medicover-genetics.com

TEST INDICATIONS

Please specify for all applicable categories

FAMILY HISTORY:	MEDICAL HISTORY:
HIGH RISK ETHNICITY:	SYMPTOMS:
OTHER:	

If applicable, please attach detailed medical record and clinical information.

FOR LABORATORY USE ONLY
F-OPR-01/14-V5-EN

ORDER NUMBER	LAB ID NUMBER	KIT LOT NUMBER
COMMENTS	DATE & TIME OF RECEIPT (DD/MM/YY HH:MM)	RECEIVED BY

MEDICOVER GENETICS
Neas Engomis 31, Nicosia, 2409 Cyprus
Phone: +357 22266888 Fax: +357 22266899
Web: www.medicover-genetics.com
Email: info.genetics@medicover.com

CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS
RESTRICTED

PATIENT CONSENT

By placing my signature below I hereby:

1. Confirm that I have read, or have had read to me, the attached Patient Informed Consent and that I understand it.
2. Declare that I have had the opportunity to receive counseling from my referring healthcare provider on the Ventrilia test and to discuss with the healthcare provider all aspects of the Ventrilia test and this form including the benefits, risks and limitations of the Ventrilia test as well as the reasons for performing the test and availability of alternative testing options to my satisfaction.
3. Authorize my referring healthcare provider to collect the necessary buccal swab sample, and to submit this form and transport the sample to Medicover Genetics laboratories for the purposes of conducting the tests requested with this form.
4. Authorize Medicover Genetics to use any part of or the entirety of the biological sample for the purposes of conducting the tests requested with this form.
5. Authorize Medicover Genetics to communicate the results of the test to my referring healthcare provider.
6. Confirm that all the information on this form is true to the best of my knowledge.

Your test results and any unused biological material can help Medicover Genetics improve and further develop the quality, accuracy and effectiveness of diagnosis and help us expand the scope of genetic testing. For this reason, Medicover Genetics would like to use your anonymized, de-identified (i.e. after removing all the personal information from which you can be identified) test results and unused biological material.

☑ For the above scope, I consent to the inclusion of my test results in Medicover Genetics' database, the coding, storing and using of biological material.

PATIENT/GUARDIAN SIGNATURE	DATE
Hanako Yamada	30/07/2023

HEALTHCARE PROVIDER ATTESTATION

I hereby certify and undertake that:

1. I am the referring healthcare professional ordering this test.
2. The test results will determine my patient's medical management and treatment options.
3. The patient has been informed about the nature and purpose of the testing.
4. The patient has been duly and thoroughly counseled about the test and has received all the advice necessary to provide their informed consent, including the benefits, risks, and limitations of the Ventrilia test.
5. I have answered all the patient's queries about the Ventrilia test.
6. This form has been completed according to the wishes and instructions of the patient.
7. I have obtained the patient's informed consent and have attested their signature.

HEALTHCARE PROVIDER SIGNATURE	DATE

MEDICOVER GENETICS
Neas Engomis 31, Nicosia, 2409 Cyprus
Phone: +357 22266888 Fax: +357 22266899
Web: www.medicover-genetics.com
Email: info.genetics@medicover.com
CAP ACCREDITED COLLEGE of AMERICAN PATHOLOGISTS