HEREDITARY CANCER PANELS
PREDICT&PREVENT

BARCODE

PHYSICIAN INFORMATION / [ADD TRANSLATION IN LOCAL LANGUAGE]

INSTITUTION/PRACTICE / [ADD TRANSLATION IN LOCAL LANGUAGE]	ADDRESS (STREET NAME, NO., CITY, POSTAL CODE, COUNTRY) / [ADD TRANSLATION IN LOCAL LANGUAGE]
FIRST NAME / [ADD TRANSLATION IN LOCAL LANGUAGE]	TELEPHONE NUMBER (COUNTRY CODE & NUMBER) / [ADD TRANSLATION IN LOCAL LANGUAGE]
LAST NAME / [ADD TRANSLATION IN LOCAL LANGUAGE]	E-MAIL ADDRESS (FOR REPORT ACCESS) / [ADD TRANSLATION IN LOCAL LANGUAGE]

PATIENT INFORMATION / [ADD TRANSLATION IN LOCAL LANGUAGE]

FIRST NAME / [ADD TRANSLATION IN LOCAL LANGUAGE]	ADDRESS (STREET NAME, NO., CITY, POSTCODE, COUNTRY) / [ADD TRANSLATION IN LOCAL LANGUAGE]
LAST NAME / [ADD TRANSLATION IN LOCAL LANGUAGE]	TELEPHONE NUMBER (COUNTRY CODE & NUMBER) / [ADD TRANSLATION IN LOCAL LANGUAGE]
DATE OF BIRTH (DD/MM/YYYY) / [ADD TRANSLATION IN LOCAL LANGUAGE]	GENDER (MALE/FEMALE/OTHER - SPECIFY KARYOTYPE) / [ADD TRANSLATION IN LOCAL LANGUAGE]
PERSONAL IDENTIFICATION NO. / [ADD TRANSLATION IN LOCAL LANGUAGE]	SAMPLE COLLECTION DATE (DD/MM/YYYY) / [ADD TRANSLATION IN LOCAL LANGUAGE]
REASON FOR TEST (DIAGNOSIS, PREDICTIVE, CARRIER) / [ADD TRANSLATION IN LOCAL LANGUAGE]	

DECLARATION OF CONSENT (ACCORDING TO GERMAN GENETIC DIAGNOSTICS ACT, GenDG)

Applicable only for the determination of genetic (hereditary) characteristics

The GenDG requires provision of detailed information and a written consent for all genetic investigations as well as genetic counselling prior to both predictive (applies to healthy individuals) and prenatal testing (with restrictions: prenatal testing is not performed for late manifesting disorders, including Hereditary Cancer Panels). The German Society of Human Genetics (GfH) and the Association of German Human Geneticists (BVDH) recommend clarifying the issues listed below during the information process. Please read the declaration of consent carefully and tick the boxes, in accordance with your consent.

By signing the form below I confirm that I:

- Have been fully informed by my physician about the significance and consequences of the genetic investigation, in compliance with GenDG.
- Have read/have been read the Information for Patients (page 4) which is attached to this form and which I fully understand.
- Have been given sufficient opportunity to discuss open questions.
- Authorize [insert legal entity here] to collect the necessary samples for investigation (blood, tissue, chorionic villus cells or amniotic fluid for prenatal diagnosis) and to send this form to MVZ Martinsried GmbH, Lochhamer Str. 29, 82152 Martinsried, Germany, in order to perform the tests requested through this form.
- Consent to the genetic test being carried out in order to clarify the disease/dysfunction/suspected diagnosis.

YES NO

- ☐ ☐ I agree that the investigation or parts of the investigation may be forwarded to collaborating medical laboratories, if necessary.
- ☐ ☐ I agree with the evaluation of additional genes in the same indication group as part of the research.
- ☐ ☐ I agree that the remaining specimens may be stored for further investigations after the examination is completed, yet not claiming storage.
- ☐ ☐ I agree that the specimens, and if applicable DNA sequence information, may be made available anonymously for quality management and scientific purposes.
- ☐ ☐ I agree that the results of the analysis may be stored for a longer period than the statutory period of 10 years, yet not claiming storage of results.
- ☐ ☐ I agree to the storage and use of my test results under the protection of anonymity in a statistical database used for scientific purposes and to help diagnose genetic diseases. I understand that I will remain under the protection of anonymity and I cannot be identified during the analysis of the data and that any personal information will be transformed into information of a non-personal nature.

By signing the form below I confirm that:

- I may stop the investigation at any time and ask for the results available until that time to be destroyed.
- I may withdraw any of my consents given through this form entirely or in part at any time without giving reasons.
- I will be charged for the costs incurred until the time of withdrawal of consent.
- I may choose not to be informed about the test results (right not to know).
- I know that the genetic investigation and evaluation is limited to the requested indication and no statements will be made about other diseases.
- All information I have provided is true and correct.

Communication of additional findings found during the course of the research

☐ YES, I wish to be informed about additional findings.
☐ NO, I do not wish to be informed about additional findings.

In addition,

- YES☐ NO☐ I agree that a copy of the results of the analysis may be sent to the following physician(s), in accordance with my express requests and according to [insert legal entity here] internal procedures.

DR(S) NAME

STREET

POSTCODE/CITY

COUNTRY

PLACE DATE

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN

PHYSICIAN'S SIGNATURE

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MVZ Martinsried GmbH
Lochhamer Str.29, 82152 Martinsried, GERMANY
Accreditation: DIN EN ISO 15189
www.medicover-genetics.com

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RELEVANT CLINICAL INFORMATION / [ADD TRANSLATION IN LOCAL LANGUAGE]

Interpretation of the genetic results relies on an accurate and complete clinical picture of the patient, including clinical manifestations, family medical history and previous diagnoses.

Check all boxes that apply to your patient:

☐ Patient is or has been diagnosed with cancer in the past. Age at diagnosis _____ Cancer type _____

☐ Patient has symptoms linked to a hereditary cancer, e.g., colon polyps. Symptoms _____

☐ Patient has a first-degree relative (mother, father, siblings, children) with cancer. Cancer type(s) _____

☐ Patient has several relatives in one family lineage (grandparents, aunts, uncles, cousins) with the same cancer type. Cancer type _____

☐ Patient has one or more family members diagnosed with cancer at a young age. Age at diagnosis _____ Cancer type _____

☐ Patient has a family member with a rare cancer, e.g., male breast cancer or retinoblastoma. Cancer syndrome/type _____

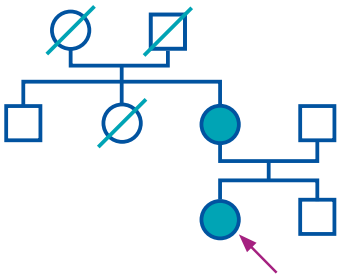
☐ Patient has family members who have done genetic testing and identified a specific variant. Gene _____ Variant _____

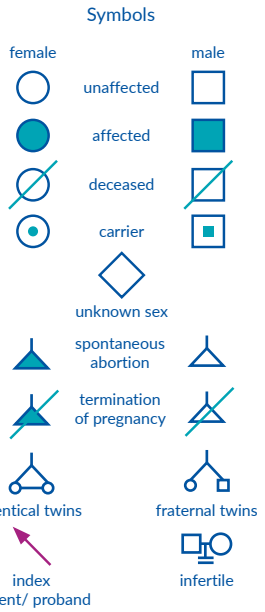
Testing the index patient will improve data interpretation. If this is not the index patient, is he/she available for genetic testing? ☐ Yes ☐ No ☐ N/A

Additional clinical information: (e.g., histopathology results, MSI (colon or endometrial cancer), type of colon polyps (adenomatous, serrated, juvenile), TNBC (breast cancer), diffuse type of gastric cancer or lobular breast cancer (CDH1), etc. Please provide all relevant medical reports.

PEDIGREE / [ADD TRANSLATION IN LOCAL LANGUAGE]

Example of a pedigree:
Hereditary Breast/Ovarian cancer





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OUR PANELS / [ADD TRANSLATION IN LOCAL LANGUAGE]

Please select the most appropriate test for your patient from the following gene panel options:

1 **COMPREHENSIVE HEREDITARY CANCER PANEL / [ADD TRANSLATION IN LOCAL LANGUAGE]**
APC, ATM, BAP1, BARD1, **BMPR1A, BRCA1, BRCA2, BRIP1,** CDC73, **CDH1,** CDK4, CDKN1B, CDKN2A, **CHEK2,** DICER1, **EPCAM, FH, FLCN,** GREM1, MAX, MEN1, **MET,** MITF, **MLH1,** MLH3, **MSH2,** MSH3, **MSH6, MUTYH,** NBN, NF1, NTHL1, **PALB2,** PMS2, POLD1, POLE, POT1, PTCH1, **PTEN, RAD51C, RAD51D,** RET, RNF43, SDHA, SDHAF2, SDHB, SDHC, SDHD, **SMAD4, STK11,** SUFU, TMEM127, TP53, VHL

2 **BREAST AND OVARIAN CANCER – BRCA1, BRCA2 / [ADD TRANSLATION IN LOCAL LANGUAGE]**
BRCA1, BRCA2

3 **BREAST AND OVARIAN CANCER – CORE PANEL / [ADD TRANSLATION IN LOCAL LANGUAGE]**
ATM, BARD1, **BRCA1, BRCA2, BRIP1, CDH1, CHEK2,** MLH1, MLH3, MSH2, MSH3, MSH6, **PALB2,** PMS2, PTEN, **RAD51C, RAD51D,** STK11, **TP53**

4 **BREAST AND OVARIAN CANCER – EXTENDED PANEL / [ADD TRANSLATION IN LOCAL LANGUAGE]**
ATM, BARD1, **BRCA1, BRCA2, BRIP1, CDH1, CHEK2,** MRE11A, MLH1, MLH3, MSH2, MSH3, MSH6, MUTYH, NBN, NF1, **PALB2,** PMS2, PTEN, **RAD51C, RAD51D,** RECQL, SMARCA4, SMARCB1, STK11, **TP53,** XRCC2

5 **COLON CANCER – CORE PANEL / [ADD TRANSLATION IN LOCAL LANGUAGE]**
APC, BMPR1A, EPCAM*, GREM1*, **MLH1, MSH2,** MSH3, **MSH6, MUTYH,** NTHL1, **PMS2,** POLD1, POLE, **PTEN, SMAD4, STK11**

6 **COLON CANCER – EXTENDED PANEL / [ADD TRANSLATION IN LOCAL LANGUAGE]**
APC, AXIN, **BMPR1A, EPCAM*,** GALNT12, GREM1*, **MLH1,** MLH3, **MSH2,** MSH3, **MSH6, MUTYH,** NTHL1, **PMS2,** POLD1, POLE, **PTEN,** RNF43, RPS20, **SMAD4, STK11**

7 **GASTROINTESTINAL TUMORS / [ADD TRANSLATION IN LOCAL LANGUAGE]**
APC, BMPR1A, CDH1, CTNNA1, **EPCAM*,** KIT, **MLH1, MSH2, MSH6, MUTYH,** PDGFRA, **PMS2, PTEN,** SDHA, SDHAF2, SDHB, SDHC, SDHD, **SMAD4, STK11**

8 **PANCREATIC TUMORS / [ADD TRANSLATION IN LOCAL LANGUAGE]**
ATM, BRCA1, BRCA2, CDKN1B, **CDKN2A, EPCAM*, MLH1,** MEN1, MSH2, MSH6, **PALB2,** PMS2, **STK11, TP53,** VHL

9 **KIDNEY CANCERS / [ADD TRANSLATION IN LOCAL LANGUAGE]**
BAP1, **FH, FLCN, MET, PTEN,** SDHA, SDHAF2, SDHB, SDHC, SDHD, **VHL**

10 **PROSTATE CANCER / [ADD TRANSLATION IN LOCAL LANGUAGE]**
ATM, BRCA1, BRCA2, CHEK2, EPCAM*, **HOXB13,** MLH1, MSH2, MSH6, **PALB2,** PMS2

11 **SKIN TUMORS / [ADD TRANSLATION IN LOCAL LANGUAGE]**
BAP1, CDK4, CDKN2A, MITF, MLH1, MSH2, MSH6, NF1, PMS2, POT1, PTCH1, PTCH2, PTEN, SUFU

12 **ENDOCRINE TUMORS / [ADD TRANSLATION IN LOCAL LANGUAGE]**
AIP, CDC73, CDKN1B, MAX, MEN1, PTEN, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL

13 **NERVOUS SYSTEM/BRAIN TUMORS / [ADD TRANSLATION IN LOCAL LANGUAGE]**
AIP, NF1, NF2, SDHA, SDHAF2, SDHB, SDHC, SDHD, SMARCA4, SMARCB1, LZTR1, SMARCE1, TP53, VHL

14 **UNSPECIFIC TUMOR SYNDROMES / [ADD TRANSLATION IN LOCAL LANGUAGE]**
BAP1, CDKN1B, DICER1, NF1, PTEN, STK11, TP53

15 **FANCONI ANEMIA / [ADD TRANSLATION IN LOCAL LANGUAGE]**
BRCA1, BRCA2, BRIP1, ERCC4, FANCA, FANCB, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, FANCM, MAD2L2, PALB2, RAD51, RAD51C, RFWD3, SLX4, UBE2T, XRCC2

*CNV analysis only
Genes in **bold** are recommended by International guidelines, including German expert panels and/or have been more often associated with specific cancers.

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HEREDITARY CANCER PANELS PREDICT&PREVENT

INFORMATION FOR PATIENTS

BARCODE

PATIENT INFORMATION / [ADD TRANSLATION IN LOCAL LANGUAGE]

FIRST NAME / [ADD TRANSLATION IN LOCAL LANGUAGE]	GENDER (MALE/FEMALE/OTHER - SPECIFY KARYOTYPE) / [ADD TRANSLATION IN LOCAL LANGUAGE]
LAST NAME / [ADD TRANSLATION IN LOCAL LANGUAGE]	TELEPHONE NUMBER (COUNTRY CODE & NUMBER) / [ADD TRANSLATION IN LOCAL LANGUAGE]
DATE OF BIRTH (DD/MM/YYYY) / [ADD TRANSLATION IN LOCAL LANGUAGE]	E-MAIL ADDRESS / [ADD TRANSLATION IN LOCAL LANGUAGE]
CLINICAL DIAGNOSIS / [ADD TRANSLATION IN LOCAL LANGUAGE]	

Genetic counselling or counselling by the ordering physician is necessary before ordering a test in order to inform the patient of all of the possible outcomes and the limitations of the genetic test.

I understand that I will be tested for:
(to be filled in by physician)

I understand that the biological sample will be used to determine if I, or members of my family, are carriers of a genetic variant causing the disease, or are carriers of the disease, or have an increased risk of developing a disease.

The role of genetic testing. In many cases, a genetic test can directly detect a genetic alteration. Molecular tests can identify structural changes in the DNA (variants). Cytogenetic tests identify the chromosomal changes (structural or numerical). The sensitivity and specificity of each test varies. The tests offered are complex analyses and are performed using high-end equipment. The methods are externally validated, but there is a minimal possibility of errors.

The significance of the results. If the result is identified as being directly causative of the clinical manifestations, it is considered to be conclusive. If the test does not identify the causative mutations of the clinical manifestations, it is considered to be inconclusive and this does not preclude other genetic changes (or non-genetic factors) responsible for the disease (a genetic disease or susceptibility to a genetic condition is not excluded). Therefore, an inconclusive result (no causative mutation identified) does not exclude the existence of other pathogenic genetic changes (variants) not tested through the current analysis.
Interpretation of the genetic results relies on a complete clinical picture of the patient, including clinical manifestations, family medical history and previous diagnoses. An error in diagnosis could occur due to a clinical picture that is different from that declared. In addition, the test can identify a possible nonpaternity. The test results will be forwarded to the patient by the geneticist or ordering physician and are confidential.

Incidental findings. Genetic testing can provide information unrelated to the purpose of the test, but that may have medical importance for the patient or family (information correlated with an increased risk for incurable disorders).

Use of the sample/result. The sample provided will be used solely for the purpose of the test and for which I have given my written consent.
Test results can also be used for research and to improve the diagnosis and treatment of genetic diseases.

The genetic material can be used for other purposes only with my prior express written consent.

Post-testing genetic counselling. A conclusive result may offer the patient information on the susceptibility, diagnosis, possible prognosis and/or heritability of the disease. An inconclusive result may lead to confusion and anxiety or may suggest the need for further genetic testing. Therefore, post-testing genetic counselling is advised for the clinical interpretation of the results.

By my signature, I hereby certify that:

1. I have been informed of the nature and purpose of the genetic test.
2. I have been informed of the benefits and limitations of the genetic test by _____ (name of physician).
3. I have been informed that the genetic test can provide information/results which have no connection with the purpose of testing. I understand that only I decide if I want those additional results to be provided.
4. I have received clear answers to my questions in relation to the genetic test.
5. I have received a copy of this form.
6. I agree to provide a sample for the above mentioned genetic test.

Completed by: ☐ Parent/Legal Guardian ☐ Patient

FIRST NAME

LAST NAME

DATE OF COMPLETION

SIGNATURE

I have explained the risks and benefits of the test as well as alternative test methods to the parent/legal guardian. I have answered all the questions from the parent/legal guardian.

Name of the ordering physician

FIRST NAME

LAST NAME

SIGNATURE OF THE ORDERING PHYSICIAN

DATE OF SIGNATURE

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