

# Order Form Liquid Biopsy

## General Information



### Patient

Surname: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Date of birth: \_\_\_\_\_  
Sex:  male  female  
External ID: \_\_\_\_\_

### Counselling Clinician

Title: \_\_\_\_\_  
Surname: \_\_\_\_\_  
First Name: \_\_\_\_\_  
E-mail: \_\_\_\_\_

In accordance with the German Genetic Diagnostics Act (GenDG), the findings of the genetic test will be forwarded to the doctor obtaining the informed consent.

### Declaration of consent

With this signature, I confirm my consent to the genetic analysis(es) and the necessary sample collection after having been informed in accordance with the Genetic Diagnostics Act (GenDG) and with knowledge of my right of revocation.

I have been informed and agree that my personal data and the data collected in the analysis will be recorded, evaluated and, if necessary, stored in pseudonymised form in scientific databases in compliance with data protection and medical confidentiality and that the test order or parts thereof will be forwarded to a specialised cooperation laboratory if necessary.

I agree that my examination results may be re-evaluated within the retention period. My doctor will be informed of any changes by e-mail.

I hereby consent to the electronic storage, processing, utilisation and transmission of all data collected by LIQOMICS GmbH.

### Please note

We update our tests at regular intervals in accordance with the current state of scientific knowledge. We would therefore like to point out that the composition of genes in a gene set may have changed slightly at the time of the laboratory analysis (addition or removal of genes).

By signing the submission form, the physician also agrees to any changes in the composition of the requested gene set. We reserve the right to decide on the sequencing technology to be used on an individual basis. We would like to point out that for technical reasons in some cases more than the requested genes may be sequenced when diagnostics are requested.

I give my consent to request findings and tumour material.

I can revoke this declaration of consent at any time without giving reasons. I have had the necessary time for consideration.

As the attending physician, I confirm that I am qualified to order genetic diagnostics for the above-mentioned patient. In the case of diagnostics for minors, I confirm that I have the consent of all authorised guardians.

If the patient has not signed the submission form: As the attending physician, I confirm and affirm that I have informed the patient about the genetic test in accordance with the Genetic Diagnostics Act and that I have the patient's written consent.

### Sender / Clinic

Institution: \_\_\_\_\_  
Street / No.: \_\_\_\_\_  
Postcode / City: \_\_\_\_\_  
Country: \_\_\_\_\_  
Phone: \_\_\_\_\_  
VAT ID: \_\_\_\_\_

If you have a value-added tax identification number, please state this.

### Invoice address

Sender / Clinic

In case of deviation:

Surname: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Institution: \_\_\_\_\_  
Street / No.: \_\_\_\_\_  
Postcode / City: \_\_\_\_\_  
Country: \_\_\_\_\_

### In the following, not ticking the box is treated as a 'No'.

I agree to the storage of sample material for the purpose of verifiability, quality assurance or for supplementary analyses (for a maximum of 10 years).

Yes  No

I agree to the storage and use of examination material and / or findings for scientific purposes, including publications in pseudonymised form.

Yes  No

### I would like to be informed about additional findings:

Yes  No

**Explanation:** In rare cases, genetic changes may be detected that are not related to the test order (so-called additional findings). If no additional findings are obtained, this does not mean that the corresponding risks have been ruled out. The results should be discussed during genetic counselling.

To be completed internally by LIQOMICS:

Patient ID: \_\_\_\_\_ Timepoint: \_\_\_\_\_

\_\_\_\_\_  
Patient / representative  
(Block letters)

\_\_\_\_\_  
Physician  
(Block letters)

\_\_\_\_\_  
Patient / representative  
(Date, Signature)

\_\_\_\_\_  
Physician  
(Date, Signature)

Physician's stamp / clinic barcode if applicable

For targeted processing, we ask you to complete the medical history form in as much detail as possible and enclose copies of any medical reports and findings you have.

### Indication / suspected diagnosis / course of the disease

### Genetic analyses already initiated / carried out

- Physician's letter enclosed
- Findings of pathology / cytology / cytogenetics / flow cytometry

#### Transplants (bone marrow, tissue, stem cells)

No

Yes,

(Please specify)

### Requirements for the test material

**2 x 10 ml cfDNA Tubes**

Liquid biopsy samples are sample material that can only be collected using special collection tubes that stabilise the cell-free DNA. Please use such tubes!

We are happy to provide these, please contact us in advance ([diagnostics@liqomics.com](mailto:diagnostics@liqomics.com)).

### Order

- LymphoVista** (Genotyping and MRD determination in lymphomas using liquid biopsy)
- LymphoVista HL** (Genotyping and MRD determination in Hodgkin lymphoma using liquid biopsy)
  
- Initial examination (For later MRD determination, initial examination is required before starting therapy!)
- Minimal Residual Disease (Only after an initial examination has already taken place)

Latest findings enclosed:  Yes  No

LIQOMICS patient ID:

### Additional information

Please do not hesitate to contact us if you have any questions or require advice.

**Website:** [www.liqomics.com](http://www.liqomics.com)

**e-mail:** [diagnostics@liqomics.com](mailto:diagnostics@liqomics.com)