

Case Number	
Reception Date	
Order Number	

(To fill-in by LabGenetics)

MUSCULAR AND SKELETAL DISORDERS GENETIC TESTING REQUEST
PATIENT OR DONOR OF THE SAMPLE

Name:	Surname:	
ID:	Age:	Clinic History N°:
Antecedents:		

MEDICAL CENTER OR LABORATORY

Name/Lab-Hospital name:		ID/VAT:
Address:		City:
State:	Post/Zip code:	Phone:
Fax:	E-mail:	

SAMPLE SENT

Reference	Sample Type (Brief description)	LabGenetics Code

TEST REQUIRED

<input type="checkbox"/> ACHONDROPLASIA	<input type="checkbox"/> OSTEOGENESIS IMPERFECTA
<input type="checkbox"/> AMYOTROPHIC LATERAL SCLEROSIS (ALS1)	<input type="checkbox"/> <u>COL1A1</u> gene Mutation Screening
<input type="checkbox"/> DOPA-RESPONSIVE DYSTONIA (DYT5)	<input type="checkbox"/> <u>COL1A2</u> gene Mutation Screening
<input type="checkbox"/> DUCHENNE/BECKER MUSCULAR DYSTROPHY	<input type="checkbox"/> OSTEOPETROSIS
<input type="checkbox"/> HIGH-BONE-MASS DISEASE	<input type="checkbox"/> <u>OSTM1</u> gene Mutation Screening
<input type="checkbox"/> HYPOCHONDROPLASIA	<input type="checkbox"/> <u>TCIRG1</u> gene Mutation Screening
<input type="checkbox"/> EARLY-ONSET TORSION DYSTONIA	<input type="checkbox"/> <u>CLCN7</u> gene Mutation Screening
<input type="checkbox"/> MYOTONIC DYSTROPHY 1 (STEINERT DISEASE)	<input type="checkbox"/> OSTEOPOROSIS
<input type="checkbox"/> MYOCLONUS-DYSTONIA (DYT11)	<input type="checkbox"/> <u>VDR</u> gene <i>BsmI</i> , <i>Apal</i> , <i>TaqI</i> and <i>FokI</i> polymorphisms
<input type="checkbox"/> NEMALINE MYOPATHY TYPE 1	<input type="checkbox"/> <u>CTR</u> gene Pro463Leu polymorphism
<input type="checkbox"/> NEMALINE MYOPATHY TYPE 2	<input type="checkbox"/> <u>COL1A1</u> gene PCOL2 and Sp1 polymorphisms
<input type="checkbox"/> NEMALINE MYOPATHY TYPE 3	<input type="checkbox"/> <u>ESR1</u> gene PvuII and XbaI polymorphisms
<input type="checkbox"/> NEMALINE MYOPATHY TYPE 4	<input type="checkbox"/> <u>IL-6</u> gene -572G-C and -174 G-C polymorphisms
<input type="checkbox"/> RAPID-ONSET DYSTONIA-PARKINSONISM (DYT12)	<input type="checkbox"/> OSTEOPOROSIS-PSEUDOGLIOMA SYNDROME
<input type="checkbox"/> DIAGNOSTIC À LA CARTE: _____	

In _____, at _____ 200__

Name: _____ Signature: _____

All confidential information data that appears in this formulary, as well as the analysis results, will be added to a file under the responsibility of LabGenetics. According with the current legislation, all people that figure in this document will be able to make use of their rights and oppose, access, rectify and cancel this data, sending an email, properly identified, to info@labgenetics.com.es

Results communication	<input type="checkbox"/> Ordinary mail	<input type="checkbox"/> Fax	<input type="checkbox"/> E-mail
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