genetikum®
GENETISCHE BERATUNG & DIAGNOSTIK

**Please give us the following information beforehand, so your doctor at the genetikum® can prepare for the counseling appointment. Please complete the questionnaire and send it to us prior to your appointment.**

ADVICE-SEEKER:

Form of address:

Last name I First name (maiden name, if applicable):

Date of birth:

Health insurance company:

if appropriate, PARTNER

Form of address:

Last name I First name (maiden name, if applicable):

Date of birth:

Health insurance company:

Street I House number:

Zip code I City:

Phone I Fax:

E-mail:

**Brief description of your problem / question:**

**The following medical conditions of the affected person/partner/child are known:**
(If possible, please specify when and where treatment has taken place)

**The following medical conditions are known in the family:**
(If possible, please specify when and where treatment has taken place)

Last name I First name:
Date of birth:
Family relationship:
Medical condition(s):
If deceased, when?

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Last name I First name:
Date of birth:
Family relationship:
Medical condition(s):
If deceased, when?

---

Last name I First name:
Date of birth:
Family relationship:
Medical condition(s):
If deceased, when?


Dr. med. Mehnert & Partner
Ärzte und Humanbiologen

Dr. med. Karl Mehnert[1) 6)]
Dr. med. Gabriele du Bois[1) 6)]
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2) FA Pädiatrie
3) FA Allgemeinmedizin
4) Fachhumangenetiker
5) am genetikum angestellte Ärzte
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**The following details are important for a genetic evaluation of:**
- **prenatal diagnostics**
- **miscarriages**
- **unfulfilled desire for a child**
- **disabilities of unclear origin in the family.**

| | | | |
|---|---|---|---|
| **Are you currently pregnant?** | No ☐ | yes ☐ | 1st day of the last period: |
| I have children | No ☐ | yes ☐ | if yes, how many? |
| I had miscarriages | No ☐ | yes ☐ | if yes, how many? |
| I had stillbirths | No ☐ | yes ☐ | if yes, how many? |
| I have deceased children | No ☐ | yes ☐ | if yes, how many? |
| I had IVF treatment (in vitro fertilization) | No ☐ | yes ☐ | if yes, how many? |
| I had IVF with ICSI | No ☐ | yes ☐ | if yes, how many? |

You contact us directly yes ☐
You were referred yes ☐

**Referring doctor:**

Praxis/doctor's office:

First name I Last name:

Street I House number:

Zip code I City:

Phone I Fax:

**If you already have medical records, for example doctor's notes and/or hospital reports or photos, please send them together with the completed questionnaire to the genetikum®.**


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# RELEASE FROM THE DUTY OF CONFIDENTIALITY
## for request of medical documents

**The release from the duty of confidentiality has to be signed by the person whose medical documents are required, or by that person's legal representative, and sent to the genetikum®.**

## PATIENT DETAILS (OR DETAILS OF THE AFFECTED RELATIVE)

Last name: maiden name, if pertinent:

First name:

Date of birth:

Period of treatment: from: to:

Name of the treating physician/doctor's office/hospital:

Diagnosis/cause of treatment:

Case number and internal link number, if pertinent (will be filled in by the genetikum®!):

I herewith release my doctors, other medical professionals and hospitals from their obligation to maintain professional confidentiality vis-à-vis the doctors of the **genetikum®**, Wegenerstr. 15 in 89231 Neu-Ulm.

I give my permission, that the doctors of the **genetikum®** have access to and receive the medical information pertinent for the genetic evaluation.

The release from the duty of confidentiality can be revoked at any time and expires at the end of the consultation.

Place and date: signature of patient / legal representative:


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