บริษัท วีอาร์ยีน จำกัด VR Gene Company Limited
สำนักงานใหญ่ : ตึกอานันทมหิดล ชั้น 2 คณะแพทยศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย 1873 ถ.พระราม 4 แขวงปทุมวัน เขตปทุมวัน กรุงเทพมหานคร 10330
Head Office: 2nd floor Anantamahidol Building, Faculty of Medicine, Chulalongkorn University, 1873 Rama IV Rd, Pathumwan, Bangkok, 10330
Please deliver samples to: 11th Floor, Mongkut Petcharat Building, King Chulalongkorn Memorial Hospital, Rama IV Rd, Bangkok, Thailand 10330
กรุณานำส่งตัวอย่างที่: ชั้น 11 ตึกมงกุฎเพชรรัตน รพ.จุฬาลงกรณ์ 1873 ถ.พระราม 4 แขวงปทุมวัน เขตปทุมวัน กรุงเทพมหานคร 10330
โทร. Tel: +66 2256 4000 # 73102, 73104

Lab use only
Lab No. _____
Lab No. (family)
_____
_____
_____

ใบขอส่งตรวจเพื่อการบริการทางพันธุศาสตร์ (Request Form for Genomic Services) – For partners

If the specimen is incorrectly collected and sent, or if the mandatory information (*) is missing, the laboratory may refuse to accept the specimen.

Name – Surname*_____Hospital Number _____

Clinic_____ Hospital_____

Age* _____Date of birth (DD/MM/YY)*_____Diagnosis*_____

Name of requesting physician*_____Phone number*_____

E-mail* (For return of results)_____

Type of specimen ☐ EDTA blood ☐ Amniotic fluid (AF) ☐ DNA (_____ ng/µL, total_____) ☐ Others_____

Specimen of ☐ Proband only ☐ Proband and family members (Please specify, e.g. Father, Mother, Sibling, etc.)

_____

Date of specimen collection (DD/MM/YY) _____

(For lab use only) ผู้รับตัวอย่าง (ตัวบรรจง)_____วันที่รับ_____

รายการตรวจ Clinical Services (Clinical report issued)

☐ VR-C01 Newborn sequencing with gene panel (246 genes)

☐ Whole Exome Sequencing ☐ VR-C02 singleton ☐ VR-C03 trio ☐ VR-C17 Additional parents testing

☐ VR-C07 Rapid long read whole genome sequencing

☐ VR-C15 Long read whole genome sequencing (not rapid)

☐ VR-C16 Newborn sequencing with gene panel AND long read whole genome sequencing (247 genes)

รายการ Research Services (No clinical report issued)

☐ VR-R02 High molecular weight DNA extraction

Diagnosis
Pertinent clinical findings (important history, physical examination and laboratory findings) *

Provisional diagnosis*	
Differential diagnosis	Gene(s) of interest:
Human Phenotype Ontology terms (https://hpo.jax.org/)	
Pedigree chart	

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VR Gene Company Limited

Consent Form for Genetic Testing

Patient copy

Date (DD/MM/YYYY) .....

I, Mr./Mrs./Ms. .....

as the individual consenting to sample collection for genetic testing, have been fully informed about the following disease(s) or condition(s) .....

and understand the information provided.

Additional Information: For Legal Representatives Providing Consent on Behalf of a Patient

I have a relationship as [Specify Relationship] .....

as the legal representative of Master/Miss/Mr./Mrs./Ms. .....

I voluntarily consent to the above-named person undergoing genetic testing.

I have been informed about the following aspects of the genetic testing I am about to undergo:

1. **Purpose of the Test:** To study the genetic changes in gene(s) that cause the disease and/or to discover new genetic knowledge related to the disease or condition that either I or my family member has been diagnosed with, as well as to determine the appropriate and safe use of medications.
2. **Sample Collection Procedure:** This will involve drawing blood, not exceeding 5 ml (approximately 1 teaspoon). The potential side effects include pain, bleeding, or, in very rare cases, infection. If any side effects occur, I and/or my family members will receive medical care from the appropriate healthcare personnel.
3. **Expected Benefits:** The knowledge gained about genetic changes that cause diseases, risks of disease, carrier status, and risks of adverse drug reactions may potentially result in more accurate diagnosis, confirm the diagnosis, or determine carrier status. It will also assist in selecting appropriate and safe medications. Physicians can use this information for further research to explore the causes or mechanisms of the disease, as well as to develop treatments.
4. **Confidentiality:** The test will be conducted without disclosing my personal information to anyone not involved in the associated laboratory processes, analysis of results, treatment, or research, unless I have given prior consent.
5. **Incidental Findings:** Genetic changes unrelated to the disease(s) or condition(s) related to the clinical indication(s) may be discovered. These changes could be relevant to the health of myself and/or my family members.

I (please indicate) ❑ **consent** ❑ **do not consent** to being informed of these findings. The reporting of these genetic changes is at the discretion of the physician, who is not obligated to disclose incidental findings.

6. **Post-Test Sample Handling:** Upon completion of testing, I consent to the following (choose one):
   - ❑ Long-term storage of my genetic material for further testing or research as deemed appropriate, or as a comparison for other tests unrelated to my diagnosed condition. The research or study must be approved by an ethics committee and must not disclose the source of the samples, and the results will **not** be reported back to me.
   - ❑ Long-term storage of my genetic material for further testing or research as deemed appropriate, or as a comparison for other tests unrelated to my diagnosed condition. The research or study must be approved by an ethics committee and must not disclose the source of the samples, but the results **will** be reported back to me.
   - ❑ Destruction of my genetic material. I do not wish for it to be used in further testing or research.
7. **Genetic Information Storage:** My genetic information will be stored in a system that protects against data loss, damage, or unauthorized access, and will be kept in a verifiable state for an indefinite period, but no less than 5 years from the date of creation. I may request the deletion of this information at any time, and I may designate a specified person or legal heir to access my genetic information.
8. **Disclosure of Non-Paternity and/or Non-Maternity:** Genetic testing of myself and/or my family members may reveal that some family members are not biologically related to me. In such cases, the physician is not required to disclose this information to me or my family members.
9. **Communication of Genetic Test Results:** I acknowledge the following protocol regarding the communication and interpretation of my genetic test results:

   VR Gene will issue the official report directly to the ordering physician or their designated proxy of this genetic testing and not to myself, my family members, or other healthcare providers. The ordering physician or their designated proxy will review and release the results to me with their clinical recommendations and genetic counseling. Neither VR Gene nor the ordering physician are obligated to forward my genetic test report to other physicians.

I have read and understood the information provided in this consent form, and I have had the opportunity to ask questions to the physician until I fully understand. Therefore, I sign below as evidence.

Signature	Signature	Signature
(.....)	(.....)	(.....)
❑ Consenting Individual ❑ Legal Representative	Physician	Witness

Note: This consent form is made in two copies. One copy is kept by the service provider/laboratory, and the other is kept by the service recipient/tested individual.

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VR Gene Company Limited

Consent Form for Genetic Testing

Provider copy

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