Diagnostyka+
GENESIS

Diagnostyka GENESIS Sp. z o.o.
77a Jana Henryka Dąbrowskiego St., 60-529 Poznań
(9th floor, Nobel Tower)
tel. 61 62 63 436, fax 61 851 66 46,
Hotline: 601,305,306, www.genesis.pl

Annex 1

ULTRASOUND AND PRENATAL TESTING CLINIC

☐ **1st prenatal test**
☐ **2nd prenatal test**
☐ **3rd prenatal test**
☐ **amniocentesis**

Patient's name and surname: …………………………………………………………
PERSONAL ID NO:……………………………………………………………………………..

PREGNANCY (number):		Number of births:			
Applies to multiparous women:		Last birth			
		Year:	Pregnancy week:		
Current weight:		Height:			
Date of last menstruation:		Blood type:	Positive	Negative	
Fertilization method:			Natural	In vitro	
Applies only to in vitro:			Fresh oocytes: collection date: ………………………	Frozen oocytes: freezing date: ……………………………..	
Age over 35 years			yes	no	
Have you had two or more miscarriages?			yes	no	
Are your children healthy and developing properly?			yes	no	not applicable
Has a genetic defect been found in your child/fetus in previous pregnancies?			yes	no	not applicable
The birth weight of any child was less than 2.5 kg			yes, birth in week.....	no	not applicable
Were there any genetic abnormalities in the immediate family?			yes	no	
If so, which ones? Degree of kinship:					
Have there been any defects or other abnormalities in the body structure in the immediate family?			yes	no	
If so, which ones? Degree of kinship:					
Have there been people with intellectual disabilities in the family?			yes	no	
If so, which ones? Degree of kinship:					
Have you been exposed to harmful factors, drugs harmful to the fetus, stimulants, radiation?			yes	no	
If so, which ones?					
Smoking during pregnancy		yes	no		
Diabetes		yes type I, type II, G1, G2	no		
Chronic hypertension		yes	no		
Lupus erythematosus		yes	no		
Antiphospholipid syndrome		yes	no		
Preeclampsia in the previous pregnancy		yes	no	not applicable	
MEDICINES: Neoparin/Clexane	yes	no	Acard	yes	no

I declare that I have been informed by the attending physician about the purpose and diagnostic significance of the test performed. I agree to it and understand that non-invasive prenatal tests are screening tests and do not detect 100% of cases of genetic defects of the fetus. At the same time, I have been informed about the effectiveness of screening tests and I understand that an abnormal result does not mean a fetal disease, but an increased risk of its occurrence and requires further diagnostics. On the other hand, a normal test result does not mean that there is no fetal disease, but a low risk of its occurrence. I consent to the processing of my personal data in accordance

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with the provisions of the current Personal Data Protection Act, in particular the data provided by me and the results of tests for the purposes and implementation of preventive health programs and conducting scientific research.

……………………………………………………………………………………………………
Date and signature of the Patient

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Annex 4

ULTRASOUND AND PRENATAL TESTING CLINIC

STATEMENT

FILE number: ....

I, the undersigned..
(Patient's name and surname)

holder of an ID card...
(series and number)

declare that I have used/not used* health services such as preventive health programs in the field of prenatal testing programs **reimbursed by the National Health Fund** in another diagnostic center.

……………………………………………………………………………

Date and legible signature of the Patient

*delete as appropriate

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Declaration of authorization to access medical records

.... PERSONAL ID NO: ☐☐☐☐☐☐☐☐☐☐☐

Name and surname of the Patient / Underage patient*

.... PERSONAL ID NO: ☐☐☐☐☐☐☐☐☐☐☐

* Name and surname of the parent/legal guardian
(in the case of an underage patient, to be filled in by a parent/legal guardian)

....

* Name and surname of the other parent or legal guardian — Patient's address for correspondence

I. I authorize the following person to access information regarding my health condition and the health services provided:

Ms./Mr...

Address ....

Contact phone ....

....
Date and legible signature of the Patient

II. I authorize the following person to access medical documentation regarding my health condition and the health services provided:

Ms./Mr...

Address ....

Contact phone ....

....
Date and legible signature of the Patient

III. I do not authorize anyone to access (mark as appropriate):

☐ information about my health condition ☐ my medical records ☐ not applicable

....
Date and legible signature of the Patient

IV. I consent to the communication of information on test results, documents, and other medical information on the basis of the order number:

☐ ONLINE[1] ☐ PERSONAL COLLECTION

contact phone[1]..

[1] I consent to **receiving the order code for reading the result of the genetic test** in the online version on the mobile phone number indicated above. In order to collect the result of the genetic test, please visit: https://wyniki.diag.pl/.

NOTE: A specialist geneticist reserves the right to personally issue the result and medical documentation during the patient visit to the Genetic Clinic.

....
Date and legible signature of the Patient

V. I consent to the performance of the test or to the provision of a comprehensive health service.

....
Date and legible signature of the Patient

I declare and confirm with my own signature the authenticity of the personal data provided in the attached documents

....
Date and legible signature of the Patient

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Information about the personal data administrator

Please be advised that:

1. The administrator of your personal data provided for the purpose of performing diagnostic tests is: Diagnostyka GENESIS spółka z ograniczoną odpowiedzialnością with its registered office in Poznań, 77a Dąbrowskiego, 60-529 Poznań (National Court Register No. 0000169935).
2. Diagnostyka GENESIS Spółka z ograniczoną odpowiedzialnością has appointed a Data Protection Officer who, in accordance with the provisions of the GDPR, is the person supervising compliance with data protection rules in the entity in which they have been appointed.
   In order to contact them, please use the contact form: [https://genesis.pl/kontakt/dane osobowe/formularz](https://genesis.pl/kontakt/dane-osobowe/formularz) and email address: inspektor@genesis.pl.
3. Providing your personal data is a statutory requirement. Pursuant to Article 25(1) of the Act of 6 November 2008 on Patient Rights and the Patient Ombudsman, it is necessary to provide at least the following data:
   a. Surname and first name(s),
   b. Date of birth
   c. Gender,
   d. Address of the place of residence,
   e. Personal ID No., if assigned; in the case of a newborn: the mother's Personal ID No.; and in the case of persons who do not have a Personal ID No.: the type and number of the document confirming identity,
   f. If the patient is underage, completely incapacitated, or incapable of giving informed consent: the surname and first name(s) of the statutory representative and the address of his/her place of residence.
   g. Phone number, email address
4. The consequence of failure to provide personal data will be the inability of Diagnostyka GENESIS Sp. z o.o. to accept the order for the provision of genetic counseling, diagnostic tests, and other health services.
5. Your personal data will be processed in order to perform tests and fulfill the obligation to store medical records for the period resulting from Article 29 of the Act of 6 November 2008 on Patient Rights and the Patient Ombudsman; i.e., for 20 years, and in the case of children up to the age of 2 for a period of 22 years, counting from the end of the calendar year in which the last entry was made. In the event of possible claims, this period may be extended on the basis of the currently applicable law.
6. Your personal data will not be made available to unauthorized persons. Pursuant to Article 26 of the Act of 6 November 2008 on Patient Rights and the Patient Ombudsman, the entity providing health services makes medical documentation available to the patient or their statutory representative, or to a person authorized by the patient. Medical documentation may also be made available, among others, to entities providing health services, if such documentation is necessary to ensure the continuity of health services, as well as in cases expressly provided for by the currently applicable regulations.
7. You have the right to access your personal data and the right to correct them.
8. You have the right to lodge a complaint with the supervisory authority if you believe that the processing of your personal data violates the provisions of the General Data Protection Regulation (GDPR).

I have read the information:

………………………………………………………………..	………………………………………………………………………..
Place, date	Signature of the Patient/Parent/Legal Guardian

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