GENETIC REQUEST

MedLab PATHOLOGY

In order to provide an efficient service for Genetic Requests, please complete the following:

PATIENT DETAILS

Surname: _____ First Name: _____

Date of Birth: _____/ _____ / _____ Patient Number: _____

Gender: Male / Female (please circle) Ethnic Origin: _____

Gestation (if applicable): _____ weeks

TEST REQUEST

Disease Name: _____

Gene(s) to be Analysed: _____

Test for: Diagnosis / Carrier Screening / Known Family Mutation (please circle)

Clinical Symptoms: _____

_____

_____

Family History: _____

_____

Please state any Family Gene Mutation(s) if known: _____

Please also provide copies of any relevant genetic or pathology (ie. haematology) reports.

INFORMED CONSENT

PATIENT OR GUARDIAN

Please cross-out where applicable:

I consent / do not consent to be tested for the genetic test(s), which have been explained to me

I consent / do not consent for the results of this test to be available to assist in testing other family members

I consent / do not consent for DNA from this sample to be stored

I consent / do not consent for DNA to be used anonymously for relevant research

Signed: _____ Date: _____/ _____ / _____

DOCTOR

I have explained the purpose of obtaining a blood or tissue sample for genetic testing.

Requesting Doctor Name:_____

Requesting Hospital/Clinic Name:_____

Address: _____

_____ Phone:_____

Signed: _____ Date: _____/ _____ / _____

This consent form is for use with diagnostic testing. It is important to think through the implications of genetic testing for other family members. We strongly recommend genetic counselling for predictive testing in disorders such as Huntington's Disease or inherited cancers. Please contact our Customer Support department on 1800 303 249 if you have queries about consent or counselling issues.