PATERNITY For Life
DNA TESTING SPECIALISTS

RCPA
The Royal College of Pathologists of Australasia

ilac-MRA NATA Accreditation No. 19325

CLINICAL TESTING REQUEST FORM

ATTENTION: Complete all fields below. Patient must sign consent form to perform the test.

PATIENT INFORMATION

Patient Family Name:	Patient Given Names:	Gender: ☐ Male ☐ Female	DOB: ____/_____/______
Patient Address:			
Email Address:		Contact Number:	

TEST (S) REQUESTED

☐ **Pharmacogenomics (PGx)** - *Comprehensive analysis of DME's designed to give information on likely response to all drug classes.*

☐ **BRCA Germline Screening** - *NGS and MLPA analysis on BRCA1 and BRCA2 and 9 other genes commonly involved in inherited breast and ovarian cancers*

☐ **Cystic Fibrosis (CFTR) Screening**

☐ **Preconception Carrier Screening** - *covers over 700 unique inherited diseases (please see website for full list)*

☐ **Other - single gene disorders:**

PATIENT HISTORY

Please attach all relevant Pathology Reports and patient history

FAMILY HISTORY

REFERRING MEDICAL PRACTITIONER DETAILS

Name:

Practice:

Address:

Insert Medical Practioner Contact details

Phone Number:

Email (for results):

☐ By signing this form, I confirm I have counselled the patient on the purpose of the testing herein and provided information on the risks, benefits and limitations of the testing as well as the implications of the results. I confirm that I have the consent of the patient to request for testing on the sample. Post-test counselling shall be provided after results become available, if required.

Signature: ____________________________ Date: __________________

PATIENT INFORMED CONSENT STATEMENT

☐ I have been informed about the nature and the purpose of this genetic test and have received an explanation of the effectiveness and limitations of this genetic test, and all of my questions have been answered to my satisfaction.

☐ I have discussed the benefits and risks of the genetic test with my doctor/genetic counsellor. I understand that some genetic tests may have now, or in the future, medical, psychological or insurance discrimination issues for my extended family and myself.

☐ I have been informed that sometimes genetic testing can reveal secondary findings and I have discussed with my doctor if and/or how such results will be shared with me.

☐ I understand that it is up to me to decide whether I want secondary results reported back to me and what results I want reported. I understand that secondary findings may require explanation by a genetic specialist.

☐ I have been informed who may access my biological samples and that any remaining samples may be retained by the laboratory according to NPAAC and GDPR guidelines, and I have been informed who may have access to my genetic test result, which is part of my confidential medical records.

☐ I understand that an invasive procedure will be required during pregnancy to verify results found on screening tests. I understand that such procedures carry a risk, however small, to the pregnancy.

☐ I consent to having my sample collected for the purposes of genetic testing.

Patient Name: ____ Patient Signature: ___________________________________ Date: _________________

LAB USE ONLY

Lab Number		Coll. Date		Coll. Time		Sample Type:			
		Rec. Date		Rec. Time		Streck Tube:		Exp Date:	