

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: <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB: ____/____/____
Patient Address:			
Email Address:		Contact Number:	

TEST (S) REQUESTED

<input type="checkbox"/> Pharmacogenomics (PGx) - Comprehensive analysis of DME's designed to give information on likely response to all drug classes.	<input type="checkbox"/> BRCA Germline Screening - NGS and MLPA analysis on BRCA1 and BRCA2 and 9 other genes commonly involved in inherited breast and ovarian cancers
<input type="checkbox"/> Cystic Fibrosis (CFTR) Screening	<input type="checkbox"/> Extended Carrier Screening - covers over 419 genes associated with inherited conditions (please see website for full list)
<input type="checkbox"/> Other - single gene disorders:	

PATIENT HISTORY

FAMILY HISTORY

Please attach all relevant Pathology Reports and patient history	
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REFERRING MEDICAL PRACTITIONER DETAILS

Name:	<input type="checkbox"/> 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.
Practice:	
Address:	
Phone Number:	
Email (for results):	
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: