Laboratory Number

REQUEST FOR APPROVAL TO PERFORM SPECIALISED GENETIC TESTING

Complete this form in conjunction with RCH Laboratory Services procedure for requesting genetic tests. Review and approval will be by the Director of Laboratory Services.

***** Incomplete forms will not be processed and returned to the requesting clinician *****

It is the referring clinician's responsibility to ensure that the patient/carer knows the purpose of the test and that samples may be stored for future diagnostic testing.

PATIENT DEMOGRAPHICS

MRN:

Surname:

Given Name:

Date of Birth:

- ○ RCH Patient
- ○ Private / External / Parent (Complete overleaf)

REQUESTING DOCTOR

Full Name:

Provider Number:

Clinical Unit:

E-mail:

Signature:

TEST REQUEST

Disorder/disease group: -- Select from list --

Name of Gene/Gene panel:

Clinical information/Clinical Phenotype:

How will the test result change management?

Family History:

Does a sample accompany this form?

○ **YES** (attached is a signed pathology request form with a minimum of 5mL, EDTA Blood)

NO **

1) ○ A sample for DNA extraction and storage has already been sent.
2) ○ A sample will be sent once this test request form has been authorised.

○ PREFERRED TESTING LABORATORY:

Contact Name:

Contact E-mail:

Address:

Country --Select Country--

○ LABORATORY SERVICES TO SELECT

Test Cost *(if known)*: $

Laboratory Number

The Royal Children's Hospital Melbourne

Patient Agreement to pay costs of Genetic Testing

- Your doctor has requested genetic testing to assist in diagnosis and/or treatment.
- The cost of testing is not covered by Medicare and will result in an out-of-pocket expense.
- Due to the high cost of testing we require an agreement from you to pay these costs, and ask you to provide credit card details for payment prior to testing.
- The details below are an indicative cost of testing.
- Please note that the final cost of testing will depend on the final invoice received from the testing laboratory and the exchange rate at the time (for overseas testing). Any credit adjustment will occur when the final invoice is received.

Test cost	
DNA extraction	
Handling and shipping costs	*for overseas tests*
TOTAL EXPECTED TEST COST	

I accept and agree to pay the above costs.

Patient Name: _____

Name of person responsible for account: _____

Name on Credit Card: _____

Credit Card type: VISA MasterCard AMERICAN EXPRESS

Credit Card number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Expiry date: _ _ / _ _

Signature: _____

For any enquiries regarding your test billing,
please call Pathology Accounts on 9345 4933 or 9345 4934.

Thank you.
RCH Laboratory Services