# Genetic (Reproductive) Carrier Screening
# Pathology Request Form

genomic diagnostics
A Healius company

## Patient Information

Surname: ...............

First Name: ............... M ☐ F ☐

DOB: D D M M Y Y Y Y Phone: ...............

Address: ...............

............... Postcode: ...............

Medicare No.: ☐☐☐☐ ☐☐☐☐☐ ☐ No. next to name: ☐

**PATIENT INFORMATION:** Your treating practitioner has recommended that you use Genomic Diagnostics. You are free to choose your own pathology provider. However, if your treating practitioner has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your treating practitioner.

**MEDICARE ASSIGNMENT:** *(Section 20A of the Health Insurance Act 1973)* I offer to assign my right to benefits to the approved pathology practitioner ("APP") who will render the requested pathology services and any eligible pathologist determinable service(s) established as necessary by the practitioner. In the event that I am issued an account for those services, I also authorise that APP to submit my unpaid account to Medicare so that Medicare can assess my claim and issue me a cheque payable to the APP for the Medicare Benefit.

**PRIVATE PAY:** If I am not eligible for a Medicare rebate, I agree to pay for the costs of genetic testing. I understand I will be asked to make this payment prior to testing.

**Patient Signature:** ............... **Date:** ...............

............... **(Reason patient cannot sign)**

## Requesting Clinician

Name: ...............

Address: ...............

............... Postcode: ...............

Phone: ............... Fax: ...............

Provider No. ...............

Signature: ...............

## Report Copy

Name: ...............

Address: ...............

............... Postcode: ...............

Phone: ............... Fax: ...............

## Test Requested

| | MBS Criteria Met | Private Fee |
|---|---|---|
| **Genetic Carrier Screen for CF, SMA & FXS**<br>Where patient is pregnant or planning a pregnancy | ☐ **73451** | ☐ |
| **Reproductive partner testing where patient is a carrier of SMA or CF**<br>(testing for relevant gene only) | ☐ **73452** | ☐ |
| **Reproductive Partner Testing**<br>**Genetic Carrier Screen for CF, SMA & FXS**<br>(Private Pay) | | ☐ |

## Clinical Details

☐ Not Pregnant ☐ Pregnant ...............

Is there a known history of CF, SMA or FXS for the:

Patient/patient's family ☐ Yes ☐ No

Reproductive partner ☐ Yes ☐ No

If yes, please provide further details: ...............

...............

...............

...............

☐ Do not send reports to My Health Record

☐ SD (Self Determined)

## Collection Information

Sample Type: 1 x EDTA (4mL minimum)

**PERSON COLLECTING SPECIMEN TO COMPLETE:**

I certify I established the identity of the patient named on this request, collected and immediately labelled the accompanying specimen with the patient's details.

Initials: ...............

ACC Code / Location: ...............

Date of draw: D D M M Y Y Y Y Time: ☐☐ : ☐☐ am / pm

Was or will the patient be, at the time of the service or when the specimen is obtained: (✓appropriate box)

| | yes | no |
|---|---|---|
| a. a private patient in a private hospital or approved day hospital facility | ☐ | ☐ |
| b. a private patient in a recognised hospital | ☐ | ☐ |
| c. a public patient in a recognised hospital | ☐ | ☐ |
| d. an outpatient of a recognised hospital | ☐ | ☐ |

**For more information, contact us at info@genomicdiagnostics.com.au**

**1800 822 999**

**genomicdiagnostics.com.au**

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