



# Cardiac Genetics Diagnostic Test | Request Form

## FOR THE DOCTOR

This test should be requested by a medical specialist.

### Patient details

First name \_\_\_\_\_  
 Surname \_\_\_\_\_  
 Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Phone \_\_\_\_\_

### Test/s requested

	OFFICE USE ONLY
<input type="checkbox"/> Aortopathy	SG1
<input type="checkbox"/> Arrhythmogenic right ventricular cardiomyopathy	SG2
<input type="checkbox"/> Brugada syndrome	SG3
<input type="checkbox"/> Dilated cardiomyopathy	SG4
<input type="checkbox"/> Familial hypercholesterolaemia	SG5
<input type="checkbox"/> Familial hypertriglyceridaemia	SG6
<input type="checkbox"/> Hypertrophic cardiomyopathy	SG7
<input type="checkbox"/> Left ventricular non-compaction	SG8
<input type="checkbox"/> Long QT syndrome	SG9
<input type="checkbox"/> Pulmonary hypertension	SG10
<input type="checkbox"/> Vasculopathy	SG11

If you wish to order more than one test, please contact Sonic Genetics.

### Clinical information

Clinical diagnosis \_\_\_\_\_  
 Clinical information \_\_\_\_\_  
 \_\_\_\_\_  
 ECG findings \_\_\_\_\_  
 Echocardiography findings \_\_\_\_\_  
 Relevant history \_\_\_\_\_  
 A recent letter describing the patient's clinical presentation, findings, and working diagnosis is required to accompany this request form.

### Cardiac genetic testing is performed by Bioscientia.

The Bioscientia laboratory in Ingelheim, Germany, is a member of the Sonic Healthcare group of companies. Bioscientia provides a comprehensive medical genetic testing service which is accredited for medical testing by both the German regulatory authorities and the College of American Pathologists.

## Requesting doctor

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Phone \_\_\_\_\_ Provider No \_\_\_\_\_  
 I confirm that this is a request for diagnostic testing in an affected patient, that the patient has been informed about the purpose, scope and limitations of the test, and that the patient has given medical and financial consent for the test.

Signature CLINICIAN SIGNATURE Date \_\_\_\_\_

To finalise the request for your patient, please fax this complete request form to (02) 9855 5446. You can also email this request to info@sonicgenetics.com.au.

## Copy reports to

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Phone \_\_\_\_\_

## FOR THE PATIENT

- This test must be prepaid by contacting us on 1800 010 447
- The price of the test and our terms and conditions can be found on our website - www.sonicgenetics.com.au.
- Cancellation fees may apply
- Medicare benefits do not apply
- Please bring this form with you on the day of your blood collection
- Pre-test counselling is a condition of testing and is included in the test fee
- Upon payment an HGSA-qualified genetic counsellor will contact you to discuss testing.

I confirm that I have been informed about the purpose, scope and limitations of the test. I agree to my details being provided to the HGSA-qualified genetic counsellor to facilitate pre-test counselling.

Signature PATIENT SIGNATURE Date \_\_\_\_\_

## FOR THE COLLECTOR

### Sample collection instructions

Please collect 2 x 4 mL dedicated whole blood EDTA tubes, store at room temperature.

I certify I established the identity of the patient named on this request, collected and immediately labelled the accompanying specimen(s) with the patient's name, DOB and date/time of collection.

Signature COLLECTOR SIGNATURE Date \_\_\_\_\_

Collector initials	<input type="checkbox"/> 2 x 4 mL EDTA tubes	PAY CAT <b>SGU</b>
Location code	Date collected / /	
Collection type	Time collected :	