Sonic Genetics

Service available through Sonic Healthcare practices:

Douglass Hanly Moir Pathology
Sullivan Nicolaides Pathology
Melbourne Pathology
Barratt & Smith Pathology
Capital Pathology
Clinipath Pathology
Bunbury Pathology
Clinpath Pathology
Hobart Pathology
Launceston Pathology
North West Pathology
Southern.IML Pathology

Cardiac genetics diagnostic testing | Request form

FOR THE MEDICAL SPECIALIST OR CONSULTANT PHYSICIAN

Patient details

First name _____

Surname _____

Date of birth ____/____/____ Sex _____

Address _____

_____

_____

Phone (mobile) _____

Test requested

	OFFICE USE ONLY
☐ Aortopathy	SG1
☐ Arrhythmogenic right ventricular cardiomyopathy	SG2
☐ Brugada syndrome	SG3
☐ Dilated cardiomyopathy	SG4
☐ Familial hypertriglyceridaemia	SG6
☐ Hypertrophic cardiomyopathy	SG7
☐ Left ventricular non-compaction	SG8
☐ Long QT syndrome	SG9
☐ Pulmonary hypertension	SG10
☐ Vasculopathy	SG11

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

Testing for familial hypercholesterolaemia (FH) may be rebated by Medicare and is available through our Australian laboratory. For further information, please refer to sonicgenetics.com.au/fh

Clinical information

_____

_____

_____

☐ A recent letter describing the patient's clinical presentation, findings, and working diagnosis is required to accompany this request form.

Genetic counselling

☐ Pre-test counselling is a condition of testing and included in the test fee.
Upon payment, a qualified genetic counsellor will contact you to discuss testing.

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.

DOCTOR SIGNATURE

X _____ Date

Copy reports to

Name _____

Address _____

_____

_____

FOR THE PATIENT – Patient and Financial Consent

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

ACCOUNT STATEMENT

I understand that as the test requested is not eligible for a Medicare rebate, I will pay in full prior to the sample being tested. Cancellation fees may apply.

PATIENT SIGNATURE

X _____ Date

Please make sure to bring this request form with you on the day of your sample collection. Payment is required at the time of sample collection. **Costs will vary widely depending upon the tests required.** This will need to be discussed with your doctor.

For pricing, please refer to our website – sonicgenetics.com.au
For any enquiries, please contact Sonic Genetics on 1800 010 447.

FOR THE COLLECTOR

Please call Sonic Genetics on 1800 010 447 to complete payment and for pre-test genetic counselling instructions.

I certify that 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.

Collector initials	☐ 2 x 4 mL EDTA	Patient initials
Location code	Date collected / /	PAY CAT **SGU**
Collection type	Time collected :	

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.

SONIC HEALTHCARE

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