Sonic Genetics
Quality is in our DNA

Free-of-charge male partner testing | Request form

FOR THE DOCTOR

This gene-specific carrier screen is provided free-of-charge to male partners as an extension of our reproductive carrier screening service. Please do not use this form for general reproductive carrier screening.

Patient details

First name _____

Surname _____

Date of birth ____/____/____ Sex Male

Address _____

_____

_____

Phone (mobile) _____

Medicare No. ☐☐☐☐☐☐☐☐☐☐

PATIENT STATUS AT TIME OF SERVICE OR SPECIMEN COLLECTION
(Required by law for all patients) Was the patient a:

Private patient in a private hospital or approved day hospital?	☐ Yes	☐ No
Hospital patient in a recognised hospital?	☐ Yes	☐ No
Private patient in a recognised hospital?	☐ Yes	☐ No
Outpatient of a recognised hospital?	☐ Yes	☐ No

Hospital _____ Ward _____

Test requested

Please select test for which female partner was reported as a carrier.

☐ Cystic fibrosis (CF)

☐ Spinal muscular atrophy (SMA)

Free male partner testing is valid for 3 months from date of female partner report and is available through your local Sonic Healthcare pathology practice. Please note, a different pathology provider may not honour this free-of-charge test if Medicare benefits do not apply.

Clinical information

Is there a family history of CF or SMA? ☐ Yes ☐ No

If yes, please provide details: _____

_____

_____ ☐ SD

Female partner with carrier mutation Lab ID _____

Your doctor has recommended that you use one of the subsidiaries affiliated with Sonic Healthcare Limited, an Approved Pathology Authority. You are free to choose your own pathology provider. However, if your doctor 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 doctor.

PRIVACY NOTE The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update enrolment records. Its collection is authorised by provisions of the Health Insurance Act 1973. The information may be disclosed to the Department of Health and Ageing or to a person in the medical practice associated with this claim, or as authorised/required by law.

Requesting doctor

Name _____

Address _____

_____

_____

Phone _____ Provider No. _____

I confirm that this patient has been counselled about the purpose, scope and limitations of the test and has given consent.

DOCTOR SIGNATURE

X

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.

If I do not fulfil the Medicare criteria

ACCOUNT STATEMENT
I understand that should I not qualify for a Medicare rebate, the pathology provider will not charge me for the test.

If I do fulfil the Medicare criteria

MEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973):
I offer to assign my right to benefits to the Approved Pathology Practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner.

PATIENT SIGNATURE

X

Practitioner's Use Only (Reason for patient being unable to sign)

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

FOR THE COLLECTOR

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.

Collector's name: _____

Collector's initials	☐ 1 x 4 mL EDTA	PAY CAT
Location code	Date collected / /	
Collection type	Time collected :	