



Cardiac genetics diagnostic test | Request form

FOR THE MEDICAL SPECIALIST OR CONSULTANT PHYSICIAN

Patient details

First name _____
 Surname _____
 Date of birth ____/____/____ Sex _____
 Address _____

 Phone (mobile) _____

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 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.

*Testing for familial hypercholesterolaemia (FH) may be rebated by Medicare and is available through our Australian laboratory. For further information, please refer to www.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 HGSA-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

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 the HGSA-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

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 - www.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 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	<input type="checkbox"/> 2 x 4 mL EDTA	PAY CAT SGU
Location code	Date collected / /	
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.