



# Reproductive genetic counselling referral form

## To be eligible for this service:

- The referral for genetic counselling must be received within two months of the date of the latest eligible report was issued by Sonic Genetics.

## Reproductive carrier screening:

- Both partners must be carriers for the same autosomal recessive disorder, or the female partner is a carrier for an X-linked disorder.
- At least one partner must have had carrier testing through Sonic Genetics.

## Non-invasive prenatal testing (NIPT):

- Received high-risk result on NIPT testing through Sonic Genetics.

**FOR THE DOCTOR:** Please complete the following and fax to 1800 951 829, or send via email to [geneticcounselling@sonicgenetics.com.au](mailto:geneticcounselling@sonicgenetics.com.au)

### Patient details

First name \_\_\_\_\_  
Surname \_\_\_\_\_  
Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone \_\_\_\_\_  
Laboratory ID \_\_\_\_\_  
Pregnant ☐ Yes ☐ No Gestational age (weeks): \_\_\_\_\_

### Partner details (if reproductive carrier screening)

First name \_\_\_\_\_  
Surname \_\_\_\_\_  
Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone \_\_\_\_\_  
Laboratory ID (if tested through Sonic Genetics) \_\_\_\_\_  
OR ☐ Copy of carrier screen result attached (if tested elsewhere)

### Clinical information

Please confirm which clinical condition you wish to be addressed:

- |   |  |
|---|--|
| <input type="checkbox"/> Cystic fibrosis              | <input type="checkbox"/> Spinal muscular atrophy |
| <input type="checkbox"/> Fragile X syndrome           | <input type="checkbox"/> Trisomy 13              |
| <input type="checkbox"/> Trisomy 21                   | <input type="checkbox"/> 22q11.2 deletion        |
| <input type="checkbox"/> Trisomy 18                   |  |
| <input type="checkbox"/> Sex chromosome aneuploidy    |  |
| <input type="checkbox"/> Other (please specify) _____ |  |

### Requesting doctor

The patient/couple is aware that genetic counselling has been requested on their behalf and that a genetic counsellor will contact them directly to arrange counselling.

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone \_\_\_\_\_  
Provider No \_\_\_\_\_

 Signature **DOCTOR SIGNATURE**

I understand that the counsellor will advise when the session has been completed or if it is declined.

Free genetic counselling is only available to patients that have paid Sonic Genetics (or one of the subsidiaries of Sonic Healthcare Limited) for testing.