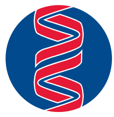

Sonic Genetics
Quality is in our DNA

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 ____/____/____ Sex ______

Address ______

______

______

Phone ______

Email ______

Test/s requested

Test	OFFICE USE ONLY
☐ Aortopathy	SG1
☐ Arrhythmogenic right ventricular cardiomyopathy	SG2
☐ Brugada syndrome	SG3
☐ Dilated cardiomyopathy	SG4
☐ Familial hypercholesterolaemia	SG5
☐ 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.

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 ✗ DOCTOR 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. Please also provide this form to your patient.

Copy reports to

Name ______

Address ______

______

Phone ______

FOR THE PATIENT – Patient and Financial Consent

Payment is required at time of sample collection

- For pricing and terms and conditions, please refer to our website – www.sonicgenetics.com.au.
- Cancellation fees may apply.
- **Medicare benefits do not apply.**
- Please make sure to bring this request form with you on the day of your sample 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	☐ 2 x 4 mL EDTA tubes	PAY CAT
Location code	Date collected / /	SGU
Collection type	Time collected :	