



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

- Aortopathy
- Arrhythmogenic right ventricular cardiomyopathy
- Brugada syndrome
- Dilated cardiomyopathy
- Familial hypercholesterolaemia
- Familial hypertriglyceridaemia
- Hypertrophic cardiomyopathy
- Left ventricular non-compaction
- Long QT syndrome
- Pulmonary hypertension
- Vasculopathy

OFFICE USE ONLY

- SG1
- SG2
- SG3
- SG4
- SG5
- SG6
- SG7
- SG8
- SG9
- SG10
- 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	<input type="checkbox"/> 2 x 4 mL EDTA tubes	PAY CAT
Location code	Date collected / /	SGU
Collection type	Time collected :	