ihbi Institute of Health and Biomedical Innovation

Genomics Research Centre Diagnostic Testing Request Form

Send by express courier: **Attention: Clinic Manager** GENOMICS RESEARCH CENTRE (GRC) Clinic Institute for Health and Biomedical Innovation Queensland University of Technology 5 School Street (Loading Bay) Kelvin Grove 4059, Brisbane, Queensland Ph: 07 3138 0970 **OR** 07 3138 0970 Fax: 07 3138 6039 Send samples with an ice brick, by courier same day OR overnight to avoid sample rejection	**Patient ID** *(items in bold required)*: **Last name:** ______________________ **First name:** ______________________ **Address:** ______________________ ______________________ Phone: ____________ Mobile: ____________ **D.O.B (dd/mm/yy):** _____ /______ /_______ **Sex:** ☐ Male ☐ Female
Test(s) Requested: *(required)* ☐ Next Generation Sequencing – Whole Exome Sequencing ☐ Specify Gene or disorders:____________________ ______________________ ☐ Next Generation Sequencing – Targeted Five Gene Panel (Combined test FHM1, FHM2, FHM3, CADASIL and SCA6 – all genes and major exons) ☐ Targeted Mutation Sequencing ☐ Specify Gene and mutation requiring confirmation:____________________ ☐ MTHFR C677T polymorphism	**Billing Status**: *(required)* **Please indicate the name of the person or department to receive the account:** ______________________ ______________________ ______________________ ______________________ **Note: There is NO MEDICARE REBATE for these tests**
Purpose of test: ☐ Confirm Clinical ☐ Diagnosis Carrier Status ☐ Family Study ☐ For Research ☐ Bank DNA until further notice ☐ Family/pedigree information ☐ Other, Specify:______________________	**Genetic Counselling:** *(required)* Has the individual been offered counselling? ☐ Yes ☐ No **Consent to testing:** *(required)* Has a Consent Form for Specialised/DNA Testing been completed? ☐ Yes ☐ No *Please refer to the GRC Diagnostic Testing Information Package for additional information*

ADDITIONAL ITEMS OVERLEAF

Sample Requisition: *(items in bold required)*

Collection By: ___________________________________

Date (dd/mm/yy): _____/_____/_____

Time (hh:mm):____/_____

Blood *(min 5mL- select appropriate)*

- ☐ EDTA _____ mL
- ☐ Lithium Heparin _____ mL
- ☐ DNA:
  - Concentration: _______________
  - Storage: ☐ TE or ☐ Water
  - 260/280 ratio:_______________
  - 260/230 ratio:_______________

Please refer to the GRC Diagnostic Testing Information Package for additional information

Family Information:

Have samples from this family been sent to the GRC for testing before?

☐ Yes ☐ No

Specify Name:_________________________________

Country of birth:_______________________________

Ethnic background: _____________________________

Is patient the index case?

☐ Yes ☐ No

Specify Name of Index:__________________________

D.O.B (dd/mm/yy) _____/_____/_____

Relationship to this patient:______________________

Copy of report to:

Name: ____

Initials: ....

Address: ______________________________________

____

Phone: _______________ Provider #: _____________

Test requested by: *(required)*

Name: ____

Initials: ....

Address: ______________________________________

____

Phone: _______________ **Provider** #: _____________

Signature:____________________________________

Clinical Notes