



Genomics Research Centre Diagnostic Testing Request Form

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

ADDITIONAL ITEMS OVERLEAF

GRC	Forms Folder	Diagnostic Request Form
Amended: 02/06/22 Review By: 02/06/25	Printed: 2/6/22	Version 1.1 Authorised: R. Smith

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