Centre for Genomics and Personalised Health

Genomics Research Centre Diagnostic Testing Request Form

Send by express courier:

Attention: Clinic Manager
GENOMICS RESEARCH CENTRE (GRC) Clinic
Queensland University of Technology
5 School Street (Loading Bay)
Kelvin Grove 4059, Brisbane, Queensland

Ph: 07 3138 0970
Email: grcclinic@qut.edu.au

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 Fifteen Gene Panel (Combined test for FHM1, FHM2, FHM3, EA1, EA2, SCA6, Dravet Syndrome, GEFS, CADASIL and Small Vessel Disease. All major exons – 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