Pathology Queensland

Queensland Government

Patient Details

HOSPITAL

GENDER M F | UR PREFIX | UR NO | DATE OF BIRTH (D D M M Y Y Y Y)

PATIENT SURNAME (Please print or place sticker on this area) | PATIENT FIRST NAME

PATIENT ADDRESS | CONTACT NO

Medicare Details

Patient status at the time of the service or when specimen collected (please tick) Yes

- n Private patient in a private hospital or approved day hospital facility
- n Private patient in a recognised hospital
- n Public patient in a recognised hospital
- n Outpatient in a recognised hospital
- n Bulk Bill Rural & Remote COAG

PHLEBOTOMY USE ONLY

MEDICARE NUMBER

HEALTH FUND NAME | EXP

VETERANS AFFAIRS | IRN

Indigenous status
Aboriginal n | TSI n | Both n | Non-Indigenous n | Not stated n

MEDICARE ASSIGNMENT FORM (Section 20A of the Health Insurance Act 1973) I offer to assign my rights to benefits to the approved pathology practitioner who will render the requested pathology service(s), and any eligible pathologist determinable service(s) established as necessary by the practitioner

Patient Signature X | Date / /

PRACTITIONERS USE ONLY
(Reason patient cannot sign)

Collector

I certify that I collected the accompanying sample from the above patient whose identity was confirmed by inquiry and/or examination of their name band and that I labelled the sample immediately following collection.

SURNAME OF COLLECTING PERSON (Please print) | INITIALS

Signature: _____ *Date Collected* ___/___/___ *Time Collected* _____ AM PM

Collection Details

COLLECTION CODE

- Path QLD Collect Inpatient
- Path QLD Collect Outpatient
- Ward Collect | Self Collect
- Self Collect Assist
- Others
- Patient Fasting
- PEI

CONTAINERS COLLECTED (No of Tubes)

EDTA	EDTA BBANK	URINE
SST	BL Culture	SWAB
CITRATE	ABG	HISTO
PST	FL OX	SLIDE

OTHER

REC'D TIME | INITIALS

☐ I have signed the above assignment to elect to have my pathology services bulk billed to Medicare.
Code CONVM Billing Cat PA

Your doctor has recommended that you use Pathology Queensland. You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist on clinical grounds a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor.

DOCTORS: Please complete ALL relevant areas in the red section

This is a two page form, please complete and scan both sides

LAB NO

Request Details

WARD/ CLINICAL UNIT

LAB USE ONLY

TEST REQUESTED

WES (Whole Exome Sequencing)

CLINICAL NOTES/MEDICATIONS | GESTATIONAL AGE K=

Doctor

CONSULTANT/SENIOR MEDICAL OFFICER SURNAME (Please print) | INITIALS

SURNAME OF REQUESTING DOCTOR (Please print) | AUSLAB CODE

FIRST NAME | PROVIDER NUMBER

Requesting Doctor's Signature X | Date Requested / / | Self Determine ☐

URGENT n | TEL n | PAGE n | FAX n | CONTACT NO

Copy

COPY REPORT TO: SURNAME (Please print) | INITIALS

COPY REPORT TO ADDRESS

Pathology Queensland

Queensland Government

Patient Details

HOSPITAL

GENDER UR PREFIX UR NO DATE OF BIRTH

M
F

PATIENT SURNAME (Please print or place sticker on this area) PATIENT FIRST NAME

PATIENT ADDRESS CONTACT NO

DOCTORS please note

Clinical details and family history are important when undertaking genetic testing. To assist processing the request, please provide as much additional information as possible. **Informed consent is required for an external laboratory to complete testing.**

Questions concerning genetic referrals may be directed to: Genetic-Referrals@health.qld.gov.au

Costs for public patients will be billed to the requesting clinical unit.

Where the test has the potential to lead to complex clinical issues the requesting doctor must confirm that informed consent has been provided

Genetic referral details

Testing Laboratory: **Australian Translational Genomics Centre (ATGC)**

Delivery Address: (not PO Box) **Level 2 R Wing**
Princess Alexandra Hospital

Contact Person: Lisa Anderson

Phone: 07 3443 7280

Email: atglab@qut.edu.au

Fax:

Cost:

Turn around time:

Type of test: [X] Accredited [ ] Research [ ] Unknown

Note to CSR: please ensure this form is sent with the specimen to the PCR Suite in the Central Laboratory. Do NOT forward specimen to an external laboratory

Patient Consent

I CONSENT to the genetic test and AGREE to the conditions opposite:

(Signature of patient or guardian) (Date)

(Signature of witness) (Date)

Name of Guardian:

Relationship to patient:

Informed consent for complex genetic testing

The following information has been provided to me about genetic testing:

LAB NO

1. The testing is completely voluntary and I can withdraw at any stage.
2. The testing will involve the collection of blood/ tissue/ _____
3. The sample will be used for the analysis of:
   WHOLE EXOME SEQUENCING (WES)
   (gene(s)/ genetic disease)
4. A portion of the sample may be stored in the laboratory for use as a control.
5. The test may not reveal all possible mutations in the genes tested, and mutations in other unknown genes may be responsible for the inherited condition in my family.
6. The test result may have implications for other members of my family and some test results are conditional on the family relationships being as stated.
7. The result will be held by Queensland Health and will be known to clinical staff, the testing laboratory and your referring doctor. The result will only be disclosed to third parties with your consent or if legally compelled to do so.
8. The sample remains the property of the laboratory. The sample may be stored but its' viability for future use cannot be guaranteed.

   A doctor/health professional has explained to me the potential benefits and adverse consequences of the test. I have had an opportunity to ask questions and I am satisfied with the explanations provided.

9. The results of this test being revealed to:
   - [ ] Any family member (blood relative), and spouse/partner/ _____
   - [ ] Only the following individual(s): _____
   - [ ] Other doctor(s) involved in my care: _____
   - [ ] No other individual.
10. In the event of my death the results may also be made known to: _____
11. The details of any disease-causing mutation and a de-identified confirmatory sample being made available to laboratories for testing other family members.