Genetic Request

THE DOCTORS LABORATORY

In order to provide an efficient service for Genetic Requests, please complete the following:

PATIENT DETAILS

Surname: _____

First Name: _____

Date of Birth: _____ Gender: ☐ M ☐ F

Patient Number: _____

Ethnic Origin: _____

Gestation (if applicable): _____ weeks

REFERRING DOCTOR

Name: _____

Address: _____

_____

_____

Tel: _____

Email: _____

TEST REQUEST

Disease Name: _____

Gene(s) to be Analysed: _____

Test for: ☐ Diagnosis ☐ Carrier Screening ☐ Known Family Mutation

Clinical Symptoms: _____

Family History: _____

Please state any Family Gene Mutation(s) if known: _____

Please also provide copies of any relevant genetic or pathology (ie. haematology) reports.

INFORMED CONSENT

PATIENT OR GUARDIAN

Please cross-out where applicable:

I consent / do not consent to be tested for the genetic test(s), which have been explained to me

I consent / do not consent for the results of this test to be available to assist in testing other family members

I consent / do not consent for DNA from this sample to be stored

I consent / do not consent for DNA to be used anonymously for relevant research

Signed: _____ Date: ____/____/____

DOCTOR / GENETIC COUNSELLOR

I have explained the purpose of obtaining a blood or tissue sample for genetic testing.

Signed: _____ Date: ____/____/____

This consent form is for use with diagnostic testing. It is important to think through the implications of genetic testing for other family members. We strongly recommend genetic counselling for predictive testing in disorders such as Huntington's Disease or inherited cancers. Please contact our Consultant if you have queries about consent or counselling issues.

☐ Fee to be paid by Patient/Other. **PLEASE PROVIDE ADDRESS DETAILS**

Insurance Co. _____ Membership No. _____

Patient address _____

_____

_____ Postcode _____ Contact telephone number _____

☐ Fee to be paid by Doctor/Clinic as above