CANBERRA Clinical Genomics

RCPA The Royal College of Pathologists of Australasia

NATA

Accreditation No. 20401

Accredited for compliance with NPAAC Standards and ISO 15189

Sanger Sequencing / MLPA Request Form

Test Requested: ☐ Sanger Sequencing ☐ MLPA

PATIENT DETAILS	
MRN:	Phone/ Mobile:
Surname:	Address:
Given Name: DOB:	Address *cont.*:
Sex: ☐ Female ☐ Male ☐ Unknown	Email:

REQUESTING DOCTOR	
Name:	Address:
Provider Number:	
Signature:	Email:

COPY REPORT TO	
Doctor:	Email:
Clinic's Details:	Address:

SPECIMEN INFORMATION (Collector / Sender to complete)		
Print Name:	Signature:	Date/Time of Collection:
EDTA Whole Blood Number of tubes collected:	Collect: **1 x 5-10ml EDTA** (adults) or **1 x 2-5ml EDTA** (children)	
Extracted DNA *(50-100ng/µl, total volume ≥50µl)*	Concentration: Elution Buffer:	Total Volume:
Other sample types *(i.e. buccal swab, saliva)*, details:		

REASON FOR TEST

☐ Confirmation of Previous Finding – Variant of interest was found in another family member. *Name:* *DOB:*

☐ Diagnostic – Patient currently has signs or symptoms of the disorder.

☐ Family Studies – For purpose of correlation through the family.

☐ Predictive Testing - Patient does not currently have symptoms of a disorder. Professional genetic counselling is required. Must contact the laboratory before testing.

DNA VARIANT DETAILS

No.	Gene	**Chr : Coordinates** (indicate which Human Reference Genome is used: GRch37/ GRch38)
1		
2		
3		

PATIENT CONSENT

I understand:

- My / my child's DNA will be tested for the gene(s) associated with my / my child's condition. Only the variants listed above will be analysed and interpreted
- Test results may have implications for the health care of my blood relatives
- My / my child's de-identified results may be used to help the counselling and testing of other family members
- Testing will not currently affect the ability to obtain health insurance but may affect applications for some types of risk-rated insurances such as life and income protection insurance
- Testing is voluntary and I can withdraw or cancel testing at any stage
- My/ my child's DNA sample will be stored in accordance with national diagnostic laboratory guidelines

I consent to the testing described above. The test has been explained to me by a health professional and I have had the opportunity to ask questions and I am satisfied with the explanations.

Patient / Parent / Guardian Name	Patient / Parent/ Guardian Signature	Date
Health Professional Name	Health Professional Signature	Date

Deliver samples to: Diagnostic Genomics, Building 10 - The Canberra Hospital, Yamba Drive, Garran ACT 2605

Laboratory hours: 8:30am – 4:30pm. Phone: (02) 5124 5630. Email: CCG@act.gov.au