RAPID GENETIC TESTING
RiverCity Private Hospital
Milton Road, Auchenflower QLD 4066
F: +61 7 3544 7626
E: referrals@rgtesting.com.au
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RAPIDGENETIC TESTING
Redefining the roadmap to rare disease diagnosis

WHOLE EXOME SEQUENCING – TEST REQUEST FORM

Patient details

Your Reference Number:		Biological Sex:	Male ☐ Female ☐
Last Name:	Address:	DOB:	
First Name:		Contact No:	
Middle Name(s):		Email:	

TEST AND SAMPLE COLLECTION PARTICULARS

Analysis Type	Singleton ☐

PATIENT CLINICAL INDICATION AND FAMILY HISTORY

Clinical Status	Affected ☐	Age at disease onset	Months/Years

Parental samples available	Yes ☐ No ☐	Affected siblings	Yes ☐ No ☐ N/A ☐	Parental consanguinity	Yes ☐ No ☐
Is father affected	Yes ☐ No ☐ Uncertain ☐	Is mother affected	Yes ☐ No ☐ Uncertain ☐		

Note: Clinical details and family history increase the chance of an actionable finding from genetic testing.

REQUESTED GENES OR GENE PANEL FOR ANALYSIS

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Your Reference Number:	Last Name:	DOB:

FAMILY PEDIGREE

PEDIGREE LEGEND: ☐ Male ○ Female ◇ Sex unknown ■ ● ◆ Affected ☐ ○ ◇ Unaffected

REFERRING CLINICIAN

Clinician Name:		Email:	
Provider No:		Contact No:	
Address:		Fax No:	

I confirm the patient has been informed about the purpose, scope and limitations of the testing, as well as the implications of the results. I confirm that I have the consent of the patient to request testing on their sample(s). The patient is aware that this test requires pre-payment prior to commencement of testing. Post-test counselling shall be provided after results become available, if required.

Clinician Signature:		Date:	

COPY TO DOCTORS

Clinician Name(s):		Email:	
Provider No:		Contact No:	
Address:		Fax No:	

CONSENT AND PAYMENT AUTHORISATION

I confirm that I have been informed about the purpose, scope and limitations of the testing, as well as the implications of the results. I consent to the testing as requested by the doctor. **I am aware that payment is required for testing to commence and the below email address may be used for billing purposes.**

Name:		Cost:	
Sign and Date:		Email:	

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PATIENT CONSENT FORM

Patient	Parent/guardian/representative (if applicable):
First name	First name
Last name	Last name
DOB	DOB
URN/MRN	Relationship

It is my choice for the above patient to have genomic testing by panel/exome analysis to look for changes in genes that may be associated with the following condition(s) or clinical indication(s) (Please specify condition or clinical indication OR specific genes):

About the test

I understand:

- Genomic test results are based on current knowledge, which may change in the future.

Potential outcomes

I understand:

- This test may find a cause for the condition(s).
- This test may **NOT** find a cause for the condition(s).
- The result may be of 'unknown significance', which means it cannot be understood today.
- There is a chance that genomic testing could find other medical conditions (secondary findings).
- This test may not detect all genetic changes and will not predict all future health problems.
- Genomic testing may identify unexpected family relationships.
- Further testing or information sharing may be needed to finalise the result.

Results

I understand:

- I will be told the results by a health professional.
- I can choose not to be told about the results, but the report may still be included in the patient medical record.
- Results may have implications for the health/genetic risks of the patient and their family members.
- Results from these tests may affect the ability to obtain some types of insurance.
- The results will be available to health professionals involved in the patient's care.
  - ☐ **I acknowledge and understand that the results for this test will not be uploaded to the My Health Record**
- Results are confidential and may only be released as specified in this form, or as allowed by law.

I permit the report to be shared with health professionals involved with the care of:

☐ all relatives of the patient

☐ specific relatives: _____

The following individual can be given the results if I am unable to be contacted:

Name: _____ Contact number: _____

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PATIENT CONSENT FORM

Data and sample sharing

I understand and agree that the sample, genomic data, and related health information may be shared and stored to help advance scientific knowledge (in a de-identified format – that is, without personal identifiers such as name and address). Information from this process cannot be returned to me after it is de-identified. There will not be a direct benefit to me or my family.

Consent

I have had enough time to consider the information in this consent form and have:

- Had the opportunity to discuss genomic testing and its implications with a health professional.
- Been given access to information about genomic testing.
- Been able to ask questions until I am satisfied with the answers.
- Been offered a copy of this consent form.

I provide consent for genomic testing as summarised in this form.

Patient/Parent/Guardian signature: _____ Date: _____

Health professional signature: _____ Date: _____

Health professional name: _____