

PHARMACOGENOMIC TEST REQUEST FORM

GENESFX HEALTH PTY. LTD. ABN: 18 125 639 394 302/55 FLEMINGTON ROAD, NORTH MELBOURNE VIC 3052
PH. 1300 GENESFX (1300 436 373) WWW.GENESFX.COM

PLEASE SEND PATIENT TO A HEALTHSCOPE PATHOLOGY COLLECTION CENTRE FOR BLOOD COLLECTION. TO FIND THE CLOSEST COLLECTION CENTRE, CALL HEALTHSCOPE CUSTOMER SERVICE: 1300 453 688 OR VISIT: WWW.HEALTHSCOPEPATHOLGY.COM.AU



PHARMACOGENOMIC TESTING

Patient Last Name: _____ Given Name: _____

Sex: _____ Date of birth: _____

Address: _____

Phone: _____ Mobile Phone: _____

CURRENT MEDICATIONS (dosages):

REASON FOR TEST:

- Suspected Adverse Drug Reaction Treatment Resistant
 Planned or New Treatment Other

List Medication: _____

TEST REQUESTED (tick one box only):

- MULTIGENE TESTS:** DNAdose (CYP2D6, CYP2C19, CYP2C9 and VKORC1) Warfarin (CYP2C9 and VKORC1)
SINGLE GENE TESTS: CYP2D6 CYP2C19 CYP2C9 TPMT UGT1A

BILLING CATEGORY:

- PRIVATE Patient is aware of the cost (please tick)

PLEASE NOTE NO MEDICARE BENEFITS ARE CURRENTLY AVAILABLE FOR THE ABOVE PHARMACOGENOMIC TESTS WITH THE EXCEPTION OF TPMT WHICH HAS A MEDICARE PAYMENT BUT STILL REQUIRES AN OUT OF POCKET COST

REQUESTING DOCTOR: (Please provide address, contact number and provider number)

Name _____
Address _____
Phone _____ Fax _____
Provider number _____

COPY DOCTOR:

DOCTOR'S SIGNATURE

DATE:

I certify that the specimen(s) accompanying this request was collected from the patient named above and I established the identity of this patient by direct inquiry/and or inspection of wrist band, and immediately upon the sample being drawn I labelled the specimen(s).

SIGNED:

DATE:

X:

X:

For cheekswabs, please post the sample & this request form to Healthscope Pathology 1868 Dandenong Road, Clayton, VIC 3168