Genomic Diagnostics
LEADING THE WAY TO IMPROVE HEALTH

Test Request Form

SCN1A

GD Lab Case ID
(Internal Use Only)
MD _____
Received: _____

To optimize the accuracy of the test results interpretation, please complete entire form to avoid delays.

1. REQUESTING PHYSICIAN INFORMATION

Full Name:	
Address:	
City:	Postcode:
Email *(<**IMPORTANT**> for report notification)*:	
Phone:	Fax:
Signature of Requesting Physician:	Date:

or/and Genetic Counsellor Information *(recommended)*

Full Name:	
Address:	
City:	Postcode:
Email *(<**IMPORTANT**> for report notification)*:	
Phone:	Fax:

Send a copy of the report also to the Genetic Counsellor? ☐ Yes ☐ No

2. PATIENT INFORMATION

Last Name:	☐ Male	☐ Female
First Name:	Phone:	
Reference/Medical Record Number:	Date of Birth: DD / MM / YYYY	

Ancestry *(check all that apply)*

☐ Ashkenazi Jewish ☐ Asian ☐ Aboriginal Australia ☐ Near East/Middle East
☐ European ☐ African ☐ Native New Zealand ☐ Other: _____

Patients Conditions *(check all that apply)*

☐ Severe Myoclonic Epilepsy Infancy (SMEI) (Dravet Syndrome) ☐ Borderline SMEI (SMEB)
☐ Generalized Epilepsy with Febrile Seizures Plus (GEFS+) ☐ Intractable epilepsy of childhood (IEC)
☐ Hemiplegic Migraine (Sporadic or Familial) ☐ Other: _____

3. TEST REQUESTED

☐ SCN1A Comprehensive Test

☐ SCN1A Mutation Segregation Analysis

Specify name of variant carrier: _____

Specify relationship to variant carrier: _____

Specify variant: _____

☐ Variant Carrier Report Attached

☐ Express Service

Sample Type

☐ Blood ☐ Buccal Swab ☐ DNA [Concentration: _____ µg/mL]

4. PAYMENT

OPTION 1 ☐ Institutional **OPTION 2** ☐ Private *(Complete Private Payment Form)*

Institution:		
Contact Person:		
Address:		Post Code:
Email:		Phone:
Fax:	☐ Purchase Order No:	Contract No:

5. Once Completed Fax to Genomic Diagnostics on +61 3 9417 6863 or Return With Kit