Cancer Genetics Request Form - Specialist Referrals Only

Genomic Diagnostics

Patient Information

Surname: .....

First Name: ..... M ☐ F ☐

DOB: D D M M Y Y Y Y Phone: .....

Address: .....

..... Postcode: .....

Medicare No.: ☐☐☐☐ ☐☐☐☐☐ ☐ No. next to name: ☐

PATIENT INFORMATION: Your treating practitioner has recommended that you use Genomic Diagnostics. You are free to choose your own pathology provider. However, if your treating practitioner has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your treating practitioner.

MEDICARE ASSIGNMENT: (Section 20A of the Health Insurance Act 1973) I offer to assign my right to benefits to the approved pathology practitioner ("APP") who will render the requested pathology services and any eligible pathologist determinable service(s) established as necessary by the practitioner. In the event that I am issued an account for those services, I also authorise that APP to submit my unpaid account to Medicare so that Medicare can assess my claim and issue me a cheque payable to the APP for the Medicare Benefit.

Patient Signature: ..... Date: .....

Requesting Specialist

Name: .....

Address: .....

..... Postcode: .....

Phone: ..... Fax: .....

Provider No. .....

Email (report delivery): .....

Signature: .....

Report Copy

Name: .....

Address: .....

..... Postcode: .....

Phone: ..... Fax: .....

Test Requested

Legend: B = Breast, O = Ovarian, P = Prostate, L = Lynch

	MBS Criteria Met	Private Fee
BraOVO Gene Panel (BRC)	☐ 73296 (B/O) ☐ 73295 (O) ☐ 73304 (P)	☐
BraOVO Plus Gene Panel (BRC)	☐ 73296 (B/O) ☐ 73295 (O) ☐ 73304 (P) ☐ 73354 (L)	☐
BRCA1 & BRCA2 Genes (BRC)	☐ 73295 (O) ☐ 73304 (P)	☐
Lynch Gene Panel (LYN)	☐ 73354	☐
FAP Gene Panel (AOP)	☐ 73355	☐
Predictive Familial Cancer Test:	Gene: _____ Variant: _____	
	☐ 73297 (B/O-BRC) ☐ 73357 (Colorectal – PGT)	☐

Please provide a copy of the relative's variant report.

Genetic Counselling

☐ Provided by specialist and written informed consent provided overleaf

OR

☐ Pre-test counselling required – Note this is only covered for MBS eligible Gene Panel referrals

Gene Panel List

BraOVO (13) Gene Panel - ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, PALB2, PTEN, RAD51C, RAD51D, STK11, TP53

Lynch (5) Gene Panel – MLH1, MSH2, MSH6, PMS2, EPCAM

BraOVO Plus (18) Gene Panel – Combined BraOVO and Lynch gene panels

FAP (2) Gene Panel – APC, MUTYH

Payment for non-MBS testing is required prior to testing – see below

Family History of Cancer ☐ YES ☐ NO

Cancer Type	Relationship

Clinical Details

Comments: .....

Do not send reports to My Health Record ☐

Payment Information

IF your test is NOT covered by Medicare:

- **Full payment is required prior to blood collection.**
- **Pay online at www.gdpay.com.au OR call 1800 822 999 (Mon-Fri, 8am-6pm AEST).**

Receipt Number: Amount Paid:

Collection Information

Collect 2 x 6mL or 10mL EDTA tube at 10 minute intervals.

PERSON COLLECTING SPECIMEN TO COMPLETE:

I certify I established the identity of the patient named on this request, collected and immediately labelled the accompanying specimen with the patient's details.

Initials: ..... ACC Code / Location: .....

Date of draw: D D M M Y Y Time: ☐☐:☐☐ am / pm

Patient Informed Consent

Genomic Diagnostics

Informed Consent for Cancer Genetic Testing

This form is to be completed at the conclusion of your Genetic Counselling Consultation

I (patient), ... (print name)

of ..... (address)

hereby consent to perform the following genetic testing:

..... (insert test name)

I have been informed of and understand the following:

1. The potential outcomes of the test, including the potential benefits and risks and the implications that this may have for both myself and my relatives.
2. A blood sample will be collected from me using standard techniques, which carry very little risk.
3. The information that I have provided will remain confidential, in accordance with the Privacy Act 1988. My test results may be de-identified and used for statistical purposes.
4. A de-identified sample of my DNA may be used to assist in improving testing methods.
5. Identification of pathogenic variants within this gene(s) may assist clinicians in accurate diagnosis, the selection of appropriate treatment protocols and better patient management.
6. In some cases, DNA testing is unable to identify a genetic variant that is associated with increased risk of cancer, even though such a variant may exist. This may be due to the current lack of knowledge in the scientific community of the complete gene structure, or inability of the technology used to identify certain types of changes in genes. In addition, a genetic variant associated with an increased risk of cancer may not be detected because the pathogenic variants may occur in another gene that has not been tested.
7. If a genetic variant that is associated with increased risk of any type of cancer is not identified, this does not mean that I am at no risk of developing cancer in the future.
8. In some cases, a genetic variant of uncertain clinical significance may be detected in one or more genes.
9. Test results are based on current knowledge, which may change in the future.
10. Participation in genetic testing is completely voluntary and I may withdraw from the testing at any stage prior to the issue of my results by informing Genomic Diagnostics in writing. However, if testing is cancelled, a fee may be charged for work completed.
11. My test result may have implications for other members of my family. I have been encouraged to advise them of this result. My result may be used to facilitate the counselling and testing of other family members.
12. The test will not affect my ability to obtain Australian health insurance but could potentially affect my ability to obtain some types of life insurance and travel insurance.
13. Genetic tests are being improved and expanded continuously. Genomic Diagnostics will store my sample for a minimum of 5 years and, at my future request and with my consent, may be able to re-test the DNA by a new procedure for additional genes. However, Genomic Diagnostics does not guarantee the availability or integrity of the sample for future use.

Patient:

A Physician or Genetic Counsellor has explained the above to me and I have had the opportunity to ask questions. I am satisfied with the explanations and answers to my questions. I hereby consent to the above statements on this consent form.

Patient Signature: ..... Date: ..../..../....

Patient Name (please print): .....

Physician/Genetic Counsellor:

I have explained the potential clinical utility (including risks, benefits and alternatives) of the requested genetic test to this person and answered their questions.

Practitioner Name: ..... Practitioner Signature: .....

Phone: ..... Email: ..... Date: ..../..../....

For more information, contact us at info@genomicdiagnostics.com.au

1800 822 999 genomicdiagnostics.com.au PO Box 250, Heidelberg West, VIC 3081