Molecular Genetics Referral Form

Wellington Regional Genetics Laboratory (WRGL)
Wellington Hospital
Private Bag 7902
Wellington 6242
Tel: (04) 918 5352
Fax: (04) 385 5822
Email: MolecularSection@ccdhb.org.nz

NHI:	DOB:	Requester:	**Sample Taken:**
Family Name:	Sex: F/M	Print name:	Date:
Given Name:	DHB of Domicile	Copy to:	Time:

Clinical Details / Family History

(Please provide details of affected relatives, if relevant)

Test details

Send-away laboratory details (if appropriate / known):

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Test required:

……

Details of affected relatives, if appropriate:

……

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- ☐ Further information required (Clinician to supply)
- ☐ Diagnostic test
- ☐ Urgent / reason……
- ☐ Pregnant EDD……..

Molecular Genetics

Sample:

- □ Adult: 5ml EDTA
- □ Child: 1-2ml EDTA
- □ Baby: 1ml EDTA

- □ Cystic Fibrosis
- □ PWS/AS
- □ Fragile X
- □ Spinal Muscular Atrophy
- □ DMD / BMD
- □ HMSN / HNPP
- □ Huntington Disease
- □ DNA storage
- □ Other: please complete test details box

Muscle Biopsy / other tests

Shipping Instructions – Please send blood with this original form and consent to:

Wellington Regional Genetics Laboratory
Level 6 Ward Support Block
Wellington Hospital
Riddiford Street
WELLINGTON 6021

Phone: 04 9185352

Invoice to:

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Please note that any tests performed in external laboratories will incur a charge; the funding for which will need to be made available by your service.

Wellington Regional Genetics Laboratory

For WRGL use only

Consent for Genetic Testing / DNA Storage

Patient label

Genetic testing may be used to establish a diagnosis. Consent is given for:

Genetic Testing

Sample Type: Blood DNA Other

Condition: _____

Laboratory Location: _____

(This may occasionally be altered)

DNA / Tissue Storage (at WRGL and destination lab, if sample sent elsewhere)

Sample Type: DNA Other

1. Information from this test may be used for other family / whānau (members) to benefit from genetic testing. If you do not wish to share this information please tick box ☐
2. Genetic testing may have insurance implications.
3. In some circumstances, testing may reveal information about biological relationships.
4. On rare occasions, genetic testing may reveal findings we were not anticipating that are not related to the condition discussed. This will be discussed with you should this occur.
5. This sample may be used if additional testing is indicated for this condition in the future.
6. DNA or other tissues will be stored and may be available for personal and/or family use. Samples may be used as a positive laboratory control when testing other family members, which may involve sending the DNA sample to other genetic laboratories in other centres / countries. DNA may be used for Quality Assurance purposes.
7. DNA, and/or any results, will not be released to any other third party not involved in my care without my further consent (unless legally required to do so).
8. DNA may be returned or destroyed (contact WRGL to arrange).

I have read and understood the information given to me and have had the opportunity to ask questions. I understand that I may withdraw or modify this consent at any stage, and that such withdrawal will not affect my future health care.

Signed: _____ **Date**: _____

Patient/Parent/Guardian/Next of Kin

Signed: _____ **Date:** _____

Health Professional

As there may be a delay in receiving results of genetic tests, please state a family member that this information can be released to in the event of you not being able to receive this yourself.

Name: _____ **Telephone:** _____

Address: _____ **Relationship:** _____