

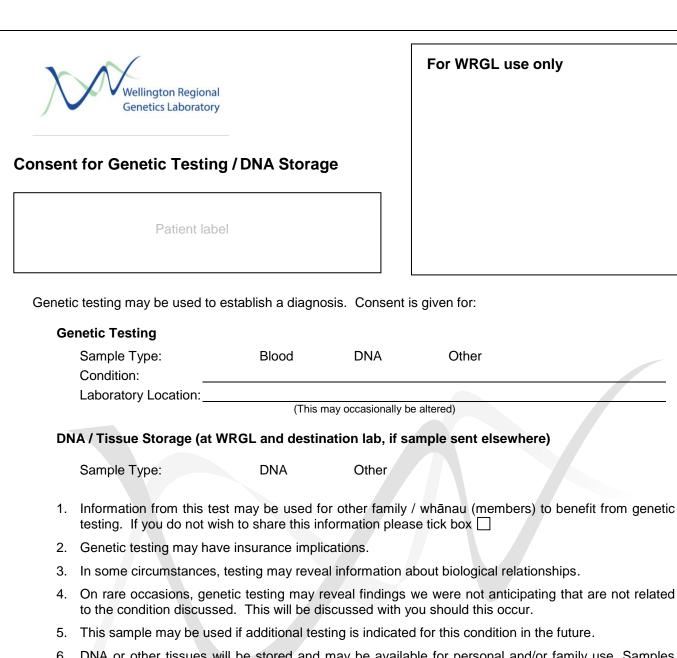
Molecular Genetics Referral Form

Wellington Regional Genetics Laboratory (WRGL) Wellington Hospital

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:	0 = 5/4	Print name:	Date:
	Sex: F/M	Copy to:	
Given Name:	DHB of Domicile	Сору со.	Time:
Civon Name.	DI ID OI DOITHOILO		
Clinical Details / Family History		Test details	
(Please provide details of affected relatives, if relevant)		Send-away laboratory details (if appropriate / known):	
		Test required:	
			,,
		Details of affected relatives, if appropriate:	
		,	
		☐ Further information required (Clinician to supply)	
		☐ Diagnostic test	
		☐ Urgent / reason	
		□ Pregnant EDD	
Molecular Genetics		Shipping Instructions - Please send blood	
Sample:		with this original form and	consent to:
□ Adult: 5ml EDTA			
□ Child: 1-2ml EDTA		Wellington Regional Genetics Laboratory	
□ Baby: 1ml EDTA		Level 6 Ward Support Block	
□ Cystic Fibrosis		Wellington Hospital Riddiford Street	
□ PWS/AS		WELLINGTON 6021	
□ Fragile X		WELLING I ON 60	/ Z *I
□ Spinal Muscular Atrophy		Db av av 04 04052	F0
□ DMD / BMD □ HMSN / HNPP		Phone: 04 91853	52
☐ Huntington Disease			
□ DNA storage		Invoice to:	
□ Other: please complete	test details box	invoice to.	
Muscle Bi	opsy / other tests		
		Please note that any tests external laboratories will in the funding for which will no available by your se	ncur a charge; eed to be made



- 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 guestions. 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	
	ay be a delay in receiving results of genetic can be released to in the event of you not being a	tests, please state a family member that this able to receive this yourself.
Name:		Telephone:

Authorised by: Clive Felix Date of Approval – 03 Oct 2017

Address: _

Wellington Regional Genetics Laboratory http://www.wellingtongenetics.co.nz/

Relationship: _____