

## Molecular Genetics Referral Form

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

<p align="center"><b>Clinical Details / Family History</b></p> <p>(Please provide details of affected relatives, if relevant)</p>	<p align="center"><b>Test details</b></p> <p>Send-away laboratory details (if appropriate / known): .....</p> <p>Specific test required: .....</p> <p>Details of any affected relatives, if appropriate (name / DOB / NHI / relationship): ..... .....</p> <p><input type="checkbox"/> Further information required (Clinician to supply)</p> <p><input type="checkbox"/> Diagnostic test</p> <p><input type="checkbox"/> Urgent / reason.....</p> <p><input type="checkbox"/> Pregnant EDD.....</p>
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<p align="center"><b>Molecular Genetics</b></p> <p><b>Sample:</b></p> <p><input type="checkbox"/> Adult: 5ml EDTA</p> <p><input type="checkbox"/> Child: 1-2ml EDTA</p> <p><input type="checkbox"/> Baby: 1ml EDTA</p> <p><input type="checkbox"/> C9orf72-related ALS / FTD</p> <p><input type="checkbox"/> CF (Cystic fibrosis)</p> <p><input type="checkbox"/> DNA storage only</p> <p><input type="checkbox"/> DM1 (Myotonic dystrophy type 1)</p> <p><input type="checkbox"/> DRPLA (Dentatorubral-pallidoluysian atrophy)</p> <p><input type="checkbox"/> DMD / BMD (Duchenne / Becker muscular dystrophy)</p> <p><input type="checkbox"/> FRAXA (Fragile X syndrome)</p> <p><input type="checkbox"/> HD (Huntington disease)</p> <p><input type="checkbox"/> HMSN / HNPP</p> <p><input type="checkbox"/> MYD88 common mutation testing</p> <p><input type="checkbox"/> PWS/AS (Prader-Willi syndrome / Angelman syndrome)</p> <p><input type="checkbox"/> SBMA (Spinobulbar muscular atrophy / Kennedy disease)</p> <p><input type="checkbox"/> SCA (Spinocerebellar ataxia)</p> <p><input type="checkbox"/> SMA (Spinal muscular atrophy)</p> <p><input type="checkbox"/> Other: please complete test details box</p>	<p><b><u>Shipping Instructions</u> – Please send blood with this original form and consent to:</b></p> <p align="center"><b>Wellington Regional Genetics Laboratory Level 6 Ward Support Block Wellington Hospital Riddiford Street WELLINGTON 6021</b></p> <p align="center"><b>Phone: 04 9185352</b></p> <p align="center"><b>Invoice to:</b></p> <p align="center">..... (billed to referring clinician if left blank)</p> <p align="center"><b>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</b></p>
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**PLEASE TURN OVER FOR PATIENT CONSENT (ESSENTIAL)**

## Consent for Genetic Testing / DNA Storage

Patient label
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### For WRGL use only

REC	
DATE / TIME	
SAMPLE	
VOL / CONDITION	
TEST REQUIRED	

**PLEASE DO NOT PUT ANYTHING IN THIS BOX**

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

Since there may be a delay in receiving results of genetic tests, please provide details of a family member to whom this information can be released in the event that you are not able to receive this yourself.

**Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_