



**Molecular Genetics (Non-GHSNZ)
Sendaway 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: Date: Time:
Family Name:	Sex: F/M	Copy to:	
Given Name:	DHB of Domicile		

<p align="center">Clinical Details / Family History</p> <p>Is there a known familial variant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, give details of affected relative (include proband report):</p> <p>NHI:</p> <p>Name/DOB:</p> <p>Relationship:</p>	<p align="center">Sendaway Test details</p> <p>Name of Sendaway laboratory (if known):</p> <p>Specific test required</p> <p><input type="checkbox"/> Single gene test</p> <p><input type="checkbox"/> Panel(s) – refer to Genomics England Panel App https://panelapp.genomicsengland.co.uk/</p> <p><input type="checkbox"/> Others:</p> <p><input type="checkbox"/> Further information required (Clinician to supply)</p>
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Type of Investigation

Diagnostic Predictive Carrier Segregation

Please note: All targeted familial variant analysis requires the involvement of Genetic Health Service NZ

Urgent / reason..... Pregnant EDD.....

<p><u>Shipping Instructions</u></p> <p>Please send blood <u>with this original form and consent</u> to:</p> <p>Wellington Regional Genetics Laboratory Level 6 Ward Support Block Wellington Hospital Riddiford Street WELLINGTON 6021 Phone: 04 9185352</p>	<p>Tests performed in overseas laboratories will incur a charge, funding for which will need to be made available by your service</p> <p>Invoice to:</p> <p>Name:</p> <p>Department:</p> <p>Email:</p>
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ALL PARTS OF THE FORM (Page 1 and 2) MUST BE COMPLETED FOR SENDAWAY TESTING. OBTAINING PATIENT CONSENT AND PROVIDING BILLING DETAILS IS ESSENTIAL

Consent for Genetic Testing / DNA Storage

Patient label

For WRGL use only**PLEASE DO NOT PUT ANYTHING IN THIS BOX**

REC	
DATE / TIME	
SAMPLE	
VOL / CONDITION	
TEST REQUIRED	

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

Genetic Testing

Sample Type: Blood DNA Other

Condition: _____

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

Sample Type: DNA Other

- 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
- Genetic testing may have insurance implications.
- In some circumstances, testing may reveal information about biological relationships.
- 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.
- This sample may be used if additional testing is indicated for this condition in the future.
- 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.
- 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).
- 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:** _____