VCGS
leaders in genetic health

VCGS General Request Form

Victorian Clinical Genetics Services
Murdoch Childrens Research Institute
The Royal Children's Hospital
Flemington Road, Parkville VIC 3052
P +61 1300 118 247 F +61 3 8341 6366
W vcgs.org.au

PATIENT DETAILS

LAST NAME | GIVEN NAMES | SEX | DATE OF BIRTH | LABORATORY REF / UR / MRN

ADDRESS | POST CODE | PHONE (home) | MOBILE

TESTS REQUESTED

SAMPLE TYPE: Li-Hep ☐ EDTA ☐ Saliva ☐
Other:

Your doctor has recommended you use Victorian Clinical Genetics Services (VCGS). You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performed the service. You should discuss this with your doctor.

MEDICARE ASSIGNMENT

Medical Assignment: (Section 20A of the Health Insurance Act 1973). I offer to assign my right to the approved pathology practitioner who will render the requested pathology service/s and any eligible pathologist determinable service/s established as necessary by the practitioner.

MEDICARE NUMBER: ________________________________

SIGNATURE: ________________________________DATE: _________

CLINICAL NOTES

SPECIMEN COLLECTION SIGNATURE

Time of collection:

SIGNATURE: Date of collection:

DOCTOR'S SIGNATURE AND REQUEST DATE

DATE:

SIGNATURE:

COPY REPORTS TO:

REQUESTING DOCTOR (provider #, initials, address):

HOSPITAL STATUS OF PATIENT AT SPECIMEN COLLECTION OR DATE OF SERVICES

YES	NO	
☐	☐	Private patient in a private hospital or approved day hospital facility
☐	☐	Private patient in a recognised hospital
☐	☐	Hospital patient in a recognised hospital
☐	☐	Outpatient of a recognised hospital

SEND SAMPLES TO:

Victorian Clinical Genetics Services
4th Floor, Murdoch Children's Research Institute
The Royal Children's Hospital
50 Flemington Road, Parkville VIC 3052
P 03 1300 118 247 W vcgs.org.au E vcgs@vcgs.org.au

Payment agreement / authorisation

for privately funded tests - complete if applicable

☐ HEALTH / OTHER SERVICE
☐ PATIENT / GUARDIAN
☐ VCGS

I/we agree to pay for the above testing

NAME: ____ COST: ____________________

SIGNED: ____ DATE: ____________________

ADDRESS: ____

____ POSTCODE: ____________________

EMAIL: ____ PHONE / MOBILE: ____________________

VCGS
leaders in genetic health

Request for saliva kit send out

Date submitted: ______________________________

Patient Name/s: ______________________________

Patient/carer mobile: ______________________________

Number of kits to send (1 per individual)*: ______________

*Notes:
Predictive genetic testing requires two separate samples per patient. Please ensure you order the correct number of kits.

Urgent sample: YES ❒ NO ❒

EMAIL TO: vcgs@vcgs.org.au

Postal address: (If different from request form)

Name: ______________________________

Postal address: ______________________________

State: ______________ Post code: ____________

Tests that can be done using saliva:
Molecular karyotype (microarray); reproductive carrier screening; fragile X; exome sequencing; Prader-Willi/Angelman syndrome; familial variant detection; parental segregation
NGS panels (e.g. cardiac, DSD).

Admin only
Date sent: ______________________________
Tracking number: ______________________________

Victorian Clinical Genetics Services
Murdoch Children's Research Institute

The Royal Children's Hospital
P 1300 118 247 **W** vcgs.org.au