VCGS
Leaders in Genetic Health

VCGS General Request Form

international

Victorian Clinical Genetics Services
Murdoch Childrens Research Institute
The Royal Children's Hospital
Flemington Road, Parkville VIC 3052
P +61 3 8341 6201 F +61 3 8341 6366
W vcgs.org.au

PATIENT DETAILS

LAST NAME	GIVEN NAMES	SEX	DATE OF BIRTH	LABORATORY REF (if applicable)
ADDRESS	POST CODE		PHONE (home)	MOBILE

TESTS REQUESTED

SAMPLE TYPE:

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

CLINICAL NOTES

SPECIMEN COLLECTION SIGNATURE

Time of collection:

SIGNATURE:

Date of collection:

DOCTOR'S SIGNATURE AND REQUEST DATE

SIGNATURE: DATE:

COPY REPORTS TO:

REQUESTING DOCTOR (initials, address):

SEND SAMPLES TO:

Victorian Clinical Genetics Services
4th Floor, Murdoch Childrens Research Institute
The Royal Children's Hospital
50 Flemington Road, Parkville VIC 3052, AUSTRALIA
P +61 3 8341 6201 W vcgs.org.au E vcgs@vcgs.org.au

VCGS Payment Agreement / Authorisation

for privately funded tests

This section must be completed.

☐ PATIENT/GUARDIAN FULL PAYMENT*
*VCGS accounts will contact you to arrange pre-payment.

☐ HEALTH SERVICE ______________________________

I authorise this test and agree to pay all associated costs.

NAME: ______________________________

SIGNED: ______________________________ DATE: ______________

If patient or guardian, please also complete below:

ADDRESS: ______________________________ POSTCODE: ______________

PHONE (home): ______________________ MOBILE: ______________________

EMAIL: ______________________________