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

VCGS payment authorisation

PATIENT DETAILS

LAST NAME:.....

GIVEN NAMES:.....

DOB:.....

UR/GF #:.....

VCGS LAB # (if known):.....

PARENTS/PARTNER/OTHER TO BE TESTED

	1.	2.
LAST NAME:	.....	.....
GIVEN NAMES:	.....	.....
DOB:	.....	.....
UR/GF #:	.....	.....
VCGS LAB # (if known):	.....	.....

TEST DETAILS

Requesting Consultant/Geneticist: .....

Test Requested: .....

Test Fee: .....

SEND INVOICE TO: ☐ VCGS ☐ PATIENT ☐ OTHER

NAME & ADDRESS:

PAYMENT AGREEMENT/AUTHORISATION

☐ VCGS ☐ OTHER HEALTH SERVICE .....

☐ PATIENT/GUARDIAN FULL PAYMENT*

*VCGS accounts may contact you to arrange pre-payment.

I agree to pay the test and all associated costs as detailed above.

Name:.....

Signed:..... Date:.....

If patient or guardian, please also complete below:

Address:..... Postcode:.....

Phone (home):..... (mobile):.....

This completed form must be submitted to the laboratory together with the Pathology Request Form and Specimen.