VCGS Leaders in Genetic Health

prepair™ genetic carrier screening

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

ADDRESS | POST CODE | PHONE (home) | MOBILE

TESTS REQUESTED

REPRODUCTIVE GENETIC CARRIER SCREENING:

Saliva /4mL EDTA Blood

NON-PREGNANT TESTING ☐ PREGNANT TESTING ☐

GESTATION (weeks): _____

EDD: _____

IS THERE A FAMILY HISTORY OF CF, FXS OR SMA?

PATIENT YES ☐ NO ☐

PARTNER YES ☐ NO ☐

IF YES, PLEASE SPECIFY:

IT IS RECOMMENDED THAT SAMPLES BE TAKEN PRE-PREGNANCY OR BEFORE 12 WEEKS GESTATION
PLEASE COMPLETE THE DETAILS OF BOTH PARENTS SO THAT THE RESULTS CAN BE LINKED IF NECESSARY
Send sample to: Victorian Clinical Genetics Services

SPECIMEN COLLECTION SIGNATURE

SIGNATURE: Time of collection: Date of collection:

DOCTOR'S SIGNATURE AND REQUEST DATE

SIGNATURE: DATE:

COPY REPORTS TO:

REQUESTING DOCTOR (provider #, initials, address):

PARTNER DETAILS

LAST NAME | GIVEN NAMES | DATE OF BIRTH

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

REPORT WILL BE SENT TO REQUESTING PRACTITIONER

PREFERRED REPORT FORMAT (tick)

☐ Email: _____

☐ Fax: _____

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Payment details

Credit card details must be completed otherwise test results will not be available. If the payment fails, you will be contacted to verify and/or make payment by another method. If payment is not confirmed within 72 hours, the test will not be processed.

CARD TYPE ☐ VISA ☐ MASTERCARD

AMOUNT TO BE DEBITED ☐ prepair $ _____

NAME ON CARD _____ SIGNATURE _____

CARD NUMBER ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ EXPIRY DATE ☐☐ ☐☐