

PATIENT DETAILS						
LAST NAME		GIVEN NAMES		SEX	DATE OF BIRTH	LABORATORY REF
ADDRESS			POST CODE	PHONE (home)	MOBILE	
TESTS REQUESTED				IS THERE A FAMILY HISTORY OF CF, FXS OR SMA?		
<p>prepair™ CARRIER SCREENING:</p> <p>4mL EDTA Blood *Testing on saliva samples can be arranged through vcgs@vcgs.org.au</p> <p><input type="checkbox"/> PREGNANT TESTING <input type="checkbox"/> NON-PREGNANT TESTING <input type="checkbox"/> DONOR (egg, sperm, embryo)</p> <p>GESTATION (weeks): _____</p> <p>EDD: _____</p>				<p>PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO specify: _____</p> <p>PARTNER <input type="checkbox"/> YES <input type="checkbox"/> NO specify: _____</p> <p>IF YES, PROVIDE DETAILS:</p>		
<p>IT IS RECOMMENDED THAT SAMPLES BE TAKEN PRE-PREGNANCY OR BEFORE 12 WEEKS GESTATION</p> <p>PLEASE COMPLETE THE DETAILS OF BOTH PARENTS SO THAT THE RESULTS CAN BE LINKED IF NECESSARY</p> <p>Send sample to: Victorian Clinical Genetics Services</p>						
SPECIMEN COLLECTION SIGNATURE			DOCTOR'S SIGNATURE AND REQUEST DATE			
SIGNATURE:		Time of collection:		SIGNATURE:		DATE:
		Date of collection:				

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 Children's Research Institute The Royal Children's Hospital 50 Flemington Road, Parkville VIC 3052 P +61 1300 11 8247 W vcgs.org.au		
<p>The report will be sent to the requesting practitioner</p>		

PATIENT COPY

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LAST NAME		GIVEN NAMES		SEX	DATE OF BIRTH	LABORATORY REF
ADDRESS			POST CODE	PHONE (home)	MOBILE	
TESTS REQUESTED				<p>Your results will be sent to the doctor who ordered your test</p> <p>REQUESTING DOCTOR (provider #, initials, address):</p>		
<p>prepair™ by VCGS</p> <p>Your sample has been sent to:</p> <p>Victorian Clinical Genetics Services 4th Floor, Murdoch Children's Research Institute The Royal Children's Hospital Flemington Rd, Parkville VIC 3052</p>						