genetic technologies

Test Request Form
Physician Use Only

Purchase Order

GTG Lab Case #
(Internal use only)
MD _____
Received _____

1. Patient Information

Last Name | Male ☐ Female ☐

First Name | Phone

Your Reference / Medical Record Number | Date Of Birth D D M M Y Y

2. Requesting Physician Information

Full Name

Address

City | Postcode

Email (for report notification)

Phone | Fax

Signature of ordering Physician _____ | Date D D M M Y Y

3. Genetic Counselor Information

Contact Person

Address

City | Postcode

Phone | Fax

Email

Would you like a copy of the report sent to you? ☐ Yes ☐ No

4. Accounts Payable Information (For institutional billing)

For private patients please download GTG payment form

Contact Person

Address

City | Postcode

Phone | Fax

Email

5. Sample Information

Test Requested (please specify)

☐ **Express Service* BRCA 1 or 2 testing only**

* Express 8 business day service is available for all BRCA gene tests, excluding BRCA1+2 Ashkenazi Testing Express which is a 5 day service (Please contact Genetic Technologies for special test requirements).

Sample Type

☐ Blood ☐ DNA [Concentration: _____ µg/ml] ☐ Tissue Block ☐ Buccal Swab

There must be at least 2 unique patient/sample identifiers on the sample collection-transport tube e.g. label the tube with the patient's name, date of birth, your reference number.

6. Once Completed Please Fax to Genetic Technologies on (+61 3) 9417 6863 or Return With Kit

***Refer to our website for Terms and Conditions: www.gtmedical.com.au**

Genetic Technologies Corporation • **Website** www.gtmedical.com.au • **Email** askus@gtmedical.com.au • **Registered Office** 60-66 Hanover Street Fitzroy VIC 3065 Australia
Postal Address PO Box 115 Fitzroy VIC 3065 Australia • **Phone:** (+61 3) 8412 7000 • **Fax** (+61 3) 9417 6863 • **Free Call** 1800 822 999 • **ABN** 92 075 962 800

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