



GTG Lab Case # (for internal use only)
MD.....
Received:.....

## Sample Submission Form

**Sample Details:** PLEASE PRINT

Sample type

Buccal Swab

Blood

DNA [concentration: \_\_\_\_\_ µg/ml]

Date obtained \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

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

**Patient Details:** \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_

(Last name)

(First name)

(Middle Initial)

Patient date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Gender  Male  Female

Your Reference / Medical Record number \_\_\_\_\_

**Test Requested:** \_\_\_\_\_

**Express Service\* BRCA and SCN1A testing only**

\*Express 5-8 business day service is for all BRCA gene and SCN1A gene tests  
(Please contact GTG for special test requirements)

### To Whom Report should be sent:

Specialist / GP / CGC name \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_

Last name

First name

MI

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Post Code \_\_\_\_\_

Telephone number ( ) \_\_\_\_\_ (work) \_\_\_\_\_ (ext)

( ) \_\_\_\_\_ (FAX)

E-mail address \_\_\_\_\_