PathWest
LABORATORY MEDICINE WA

Hospital Avenue, Nedlands
Western Australia 6009
ABN 83 469 340 804

RESULTS & ENQUIRIES
13 PATH 7284

FAMILIAL HYPERCHOLESTEROLAEMIA GENETIC TEST REQUEST FORM

PathWest Lab I.D.

PATIENT Last Name | Given Name (Including Middle Initial) | Sex | Date of Birth | Your Reference

PATIENT Address | Telephone (Home) | Telephone (Bus)

Is Patient of Aboriginal Descent? Please Tick Yes ☐ No ☐

TESTS REQUESTED

Your doctor has recommended that you use PathWest. You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor.

Specified APP: Yes / No APP Name: _____

CLINICAL NOTES

Familial Hypercholesterolaemia Gene Testing to include: LDLR, APOB, PCSK9 or familial variant

Collect 1 x 3mL EDTA tube.
Assign SOFT panel: BFHGS
Send to - PathWest FSH
Enquiries: (08) 6152 8128

Copy Reports to:

Requesting Doctor (Surname, Initials, Provider Number, Address)

✗.....

Patient Status at Time of Service or When Specimens Collected:

	YES	NO
1. A private patient in a private hospital or approved day hospital facility	☐	☐
2. A private patient in a recognised hospital	☐	☐
3. A public patient in a recognised hospital	☐	☐
4. An outpatient of a recognised hospital	☐	☐

RCPA The Royal College of Pathologists of Australasia

NATA

Date of Collection	Time of Collection	Collector's Signature *I certify that the blood specimen(s) accompanying this request was drawn from the patient named above and I established the identity of this patient by direct inquiry and/or by inspection of wrist band and immediately upon the blood being drawn I labelled the specimen(s).*
		✗.....

Practitioner Use Only ..... (Reason Patient Cannot Sign)

C D I S H N X

SOURCE / HOSPITAL

WARD

BILL TO

Date and Time Specimen Received in Laboratory

FUNDING

One of the following options **MUST** be selected

[ ] **Patient meets all of the following criteria and is eligible for testing under Medicare Benefits Schedule (Item No. 73352): Characterisation of germline variants causing familial hypercholesterolaemia (which must include the LDLR, PCSK9 and APOB genes), requested by a specialist or consultant physician, for a patient:**

(a) for whom no familial mutation has been identified; and

(b) who has any of the following: *(Please select)*

[ ] (i) a Dutch Lipid Clinic Network score of at least 6;

[ ] (ii) an LDL cholesterol level of at least 6.5 mmol/L in the absence of secondary causes;

[ ] (iii) an LDL cholesterol level of between 5.0 and 6.5 mmol/L with signs of premature or accelerated atherogenesis.

Applicable only once per lifetime

[ ] **Patient meets all of the following criteria and is eligible for testing under Medicare Benefits Schedule (Item No. 73353):**

Detection of a familial mutation for a patient who has a first or second degree relative with a documented pathogenic germline gene variant for familial hypercholesterolaemia. *(Please supply details of familial variant above)*

Applicable only once per lifetime

Medicare Assignment

(Section 20A Health Insurance Act 1973) I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner.

Patient's Signature and Date

✗.....

MEDICARE CARD NUMBER

Doctor's Statement & Signature: I confirm that I have provided genetic testing information, where appropriate, to the patient and they have consented to the test.

Doctor ✗ .....

Patient / Guardian Statement & Signature: I confirm that my doctor has explained the genetic test.

Patient / Guardian ✗ .....