



UMRN No. _____ Surname _____ Given Names _____ Date of Birth _____ Age _____ Sex _____ Address _____	Medicare Number _____	Consultant _____ Requesting Doctor _____ Surname _____ Initials _____ Address _____ Page _____ Provider Number _____ Doctors _____ Signature <b>X</b> _____ Request Date _____	Source / Hospital _____ Ward _____												
<b>TESTS REQUESTED</b>  <b>MODY Gene Panel [BMODY]</b> (Collect 1 x 3 mL EDTA tube - please forward to PathWest Fiona Stanley Hospital)		Days For Collection M T W Thu F S Su	When collecting ANTIBIOTICS and DRUG assays fill in this box: Drug Dosage Date Time												
FSH CSRA: Please put sample in CVG box in CSRA fridge.		Copy Reports to:	Date of Collection _____ Time of Collection _____												
Clinical/family history:			<table border="1"> <tr> <td>CLOT</td> <td>CIT</td> <td>HEP</td> <td>EDTA</td> </tr> <tr> <td>GLU</td> <td>ESR</td> <td>ABG</td> <td>URINE</td> </tr> <tr> <td>SWAB</td> <td>SLIDE</td> <td colspan="2">Other</td> </tr> </table>	CLOT	CIT	HEP	EDTA	GLU	ESR	ABG	URINE	SWAB	SLIDE	Other	
CLOT	CIT	HEP	EDTA												
GLU	ESR	ABG	URINE												
SWAB	SLIDE	Other													
MODY % Probability: _____ <a href="https://www.diabetesgenes.org/mody-probability-calculator/">https://www.diabetesgenes.org/mody-probability-calculator/</a>		<b>Collector's Signature</b> 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)  <b>X</b> _____ <b>Patient Status</b> at time of service or when specimens collected.  Collection Centre:  Bill To:  Patient Class:   Laboratory accredited for medical competence under the registration scheme of NATA and RCPA 													

**Patient Consent**

I, \_\_\_\_\_, consent to genetic testing on my/my child's sample. I understand that:

- In order to assist in the interpretation of this genetic test, relevant clinical information will need to be provided.
- Test results will be made available to me via the medical practitioner requesting the test.
- Test results may have implications for children and/or other family members.
- Results are confidential and will only be released to family members or authorities with consent or as required by law.
- Testing will not affect the ability to obtain health insurance, but may affect applications for some types of life insurance.
- Samples and data will be kept for the period required by laboratory regulations.
- Interpretation of genetic test results is based on the best evidence at the time of reporting; additional analysis will only periodically be undertaken after a report is issued.

Possible outcomes of genetic testing:

- One or more disease causing (pathogenic), or likely disease causing, genetic changes are identified.
- Analysis did not detect any clinically relevant genetic changes. This may be because the clinical condition (a) is not due to a genetic change, (b) is due to a genetic change in a gene not analysed in this test, or (c) is due to a change in one of the genes analysed but for technical reasons the test method was unable to detect it.
- A genetic change of uncertain significance. This means that based on current knowledge of the gene(s) involved, the laboratory is unable to say whether the genetic change is the cause of the clinical condition.
- Genetic risk factors for cardiac and metabolic conditions may be identified.

Signature (patient/guardian/next of kin): \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

<p><b>Medical Practitioner Statement</b> I have explained the nature, limitations, likely results and risks associated with the requested genetic test to this person and answered his/her questions.</p> <p>Requesting Health Professional (print name): _____</p> <p>Signature: _____ Date: ___ / ___ / _____</p>
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