LIFESTYLE GENETICS TESTING REFERRAL FORM

PATIENT DETAILS

Surname:		Given Names:	
DOB: ___ / ___ / _____	Sex:	Medicare #:	Phone:
Address:		Email:	

REQUESTING DOCTOR

Name:	Provider #:
Address:	
Phone:	Fax or Email: (for results delivery)
Copy reports to:	

I confirm the patient has been informed about the purpose, scope and limitations of the testing and, as well as the implications of the results. I confirm that I have the consent of the patient to request for testing on their sample(s). The patient is aware that this test requires pre-payment prior to commencement of testing. Post-test counselling shall be provided after results become available, if required.

Doctor's Signature: _____ Date: _____

CLINICAL INFORMATION

Please include any details that you feel may be relevant to the testing. - Please list or attach a copy of the patient's medication history, including current medications, medications under consideration, medications that have been problematic or any known drug allergies.

TEST(S) REQUESTED

☐ Folate Receptor Auto-antibody Test (FRAT)

☐ ***MTHFR* SNP Analysis**

☐ **Pharmacogenomics Premium Panel**
Includes all 8 Panel Options

☐ **Pharmacogenomics Standard Panel**
Select any 2 panel options.

☐ **Additional Panels (each)** ___
Please select. Can only be ordered in conjunction with Standard Panel

Pharmacogenomics Panel Options

- ☐ Mental Health
- ☐ Chronic Conditions
- ☐ Oncology & Haematology
- ☐ Infectiology, Antimicrobial Resistance & Organ Transplantation
- ☐ Cardiovascular
- ☐ Pain Management
- ☐ Urology & Endocrinology
- ☐ Neurology & Anaesthesiology

COLLECTION STAFF ONLY

Collector's Signature:_____ Collection Date & Time: _____

Upon completion, please return to AbsoluteDNA **along with all relevant history. Patient must sign request form to proceed.**

Phone: 1300 572 153 |direct **07** 3155 5065 | Email: info@absolutedna.**com.au** | Web: absolutedna.com.**au**