

GRC	Forms Folder	Diagnostic Request Information Version 1.9
Amended: 4/8/11	Printed: 4/8/11	Authorised: R. Smith

Specimen Collection Protocol for Diagnostic Testing

- ❖ 5mls of whole EDTA blood or 5mls of blood in Lithium Heparin is required for genetic testing. This must be **packed in ice** for transport.
Or
- ❖ The DNA extracted from 10mls of blood collected in EDTA or lithium heparin. Please indicate whether the DNA is stored in TE or water. Please ensure that 260/280 ratios are 1.6-2.1 and 260/230 ratios are 1.7-2.3 for purified DNA
- ❖ **Please Note: any specimens arriving at GRC after seven (7) days will be rejected and a recollection is required.**
- ❖ All tests take approximately six (6) to eight (8) weeks from time of receipt of blood.
- ❖ Due to the nature of Class B or predictive tests, could you please ensure that the patient receives pre- and post- counselling and that written consent has been obtained. Clinic Genetics Services can be located on the HGSA website <http://www.hgsa.com.au>
- ❖ All diagnostic tests have been listed on the HGSA website, but are not as yet Medicare rebateable.

Request Form Requirements

The request form **must contain** the items highlighted in bold, other information is optional:

- ❖ **Patients First and Surname**
- ❖ **Patients Date of Birth**
- ❖ **Patients Sex**
- ❖ **Patients Address**
- ❖ Medicare Number
- ❖ Ward and hospital if inpatient
- ❖ **Requesting Doctors Name**
- ❖ **Requesting Doctors Address**
- ❖ Provider Number
- ❖ **Doctors Signature**
- ❖ **Tests Requested**
- ❖ **Date of request**
- ❖ **Clinical Notes**
- ❖ **Names and addresses of copy doctors**
- ❖ **Date and Time of collection**
- ❖ Identity of Specimen Collector
- ❖ Type of specimen, amount and containers collected
- ❖ **Billing arrangements**

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GRC Diagnostic Testing Service

Familial Hemiplegic Migraine (FHM1)

CACNA1A gene - Exons 4, 5, 16, 17 and 36

Familial Hemiplegic Migraine (FHM2)

ATP1A2 gene - Exons 17 and 19

Familial Hemiplegic Migraine (FHM3)*

SCN1A gene - Exon 23

Episodic Ataxia Type 2 (EA2)

CACNA1A gene - Exons 22, 32 and Intron 24

CADASIL

Notch 3 gene - Exons 3 and 4

Extended CADASIL (Extra Testing)

Notch3 gene - Exons 2, 11, 18 and 19

MTHFR

MTHFR gene - C677T Polymorphism

SCA6*

CACNA1A gene - Exon 6 and 3' UTR

* Indicates test currently NOT accredited by NATA.

Specimens Labeling Requirements:

All specimens should be labeled with:

The patient's first name, surname, date of birth, date and time of collection, the patient's signature and collector's initials

Minimum specimen requirements

First name, Surname with date of birth and collection date

❖ Courier Details:

Samples must be packed on ice and sent by courier the same day, or overnight, and addressed to:

ATTENTION:

GENOMICS RESEARCH CENTRE (GRC) Clinic
Griffith University, Gold Coast Campus
Parklands Drive, Southport Qld 4215
STS Store, Glycomics 1 Building (G26), Clinical Lane, Room 3.12

Ph: 07 5552 8569 (GU Stores)

Ph: 07 5552 9771 Fax: 07 5552 9202 (GRC Clinic)

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<p>Send by express courier:</p> <p>Attention: Clinic Manager GENOMICS RESEARCH CENTRE (GRC) Clinic Griffith University, Gold Coast Campus Parklands Drive, Southport Qld 4215 STS Store, Glycomics 1 Building (G26), Clinical Lane, Room 3.12</p> <p>Ph: 0755 528569 (GU Stores) Ph: 07 555 29771 Fax: 07 555 29202 (GRC Clinic)</p> <p>Send samples with an ice brick, same day OR overnight</p>	<p>Patient ID</p> <p>Last name:.....</p> <p>First name:</p> <p>Address:.....</p> <p>Phone: Mobile:.....</p> <p>D.O.B (dd/mm/yy) ____/____/____ Sex <input type="checkbox"/>M <input type="checkbox"/>F</p>
<p>Test Requested:</p> <p><input type="checkbox"/> FHM1 (Exons 4, 5, 16, 17 & 36)</p> <p><input type="checkbox"/> FHM2 (Exons 17 & 19)</p> <p><input type="checkbox"/> FHM3 (Exon 23)</p> <p><input type="checkbox"/> EA2 (Exons 22, 32 & Intron 24)</p> <p><input type="checkbox"/> CADASIL (Exons 3 & 4)</p> <p><input type="checkbox"/> EXTENDED CADASIL (Exons 2, 11, 18 & 19)</p> <p><input type="checkbox"/> MTHFR (C677T SNP)</p> <p><input type="checkbox"/> SCA6 (Exon 6 & 3'UTR)</p>	<p>Billing Status</p> <p>Please indicate the name of the person or Department to receive the account:</p> <p>Note: There is NO MEDICARE REBATE for these tests.</p>
<p>Purpose of test:</p> <p><input type="checkbox"/> Confirm Clinical Diagnosis</p> <p><input type="checkbox"/> Carrier Status</p> <p><input type="checkbox"/> Family Study</p> <p><input type="checkbox"/> For Research</p> <p><input type="checkbox"/> Bank DNA until further notice</p> <p><input type="checkbox"/> Family/pedigree information</p> <p><input type="checkbox"/> Other, Specify:</p>	<p>Genetic Counselling</p> <p>Has the individual been offered counseling?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused</p> <p>Consent to testing</p> <p>Has a Consent Form for Specialised/DNA Testing been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Sample Requisition:</p> <p>Collection By: _____</p> <p>Date (dd/mm/yy) ____/____/____</p> <p>Time (hh:mm)____/____</p> <p>Blood</p> <p>EDTA _____ mL</p> <p>Lithium Heparin _____ mL</p> <p>Other</p> <p>DNA (Conc & stored in) _____ & _____</p>	<p>Family Information</p> <p>Have samples from this family been sent to the GRC for testing before? <input type="checkbox"/> No <input type="checkbox"/> Yes, If Yes,</p> <p>Specify Name:</p> <p>Country of birth:</p> <p>Ethnic background:</p> <p>Is patient the index case? <input type="checkbox"/> Yes <input type="checkbox"/> No, If No,</p> <p>Specify Name of Index: D.O.B (dd/mm/yy) ____/____/____</p> <p>Relationship to this patient:</p>
<p>Copy of report to:</p> <p>Name: Initials:</p> <p>Address:.....</p> <p>.....</p> <p>.....</p> <p>Phone: Provider #:</p>	<p>Test requested by:</p> <p>Name:..... Initials:</p> <p>Address:</p> <p>.....</p> <p>.....</p> <p>Phone: Provider #:</p> <p>Signature:.....</p>

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Clinical Notes: