PHARMACOGENOMIC TEST REQUEST FORM

*** mandatory fields**

PATIENT DETAILS

Forename* _____ **Surname*** _____

Patient ID _____ **DOB*(DD/MM/YYY)** _____

Biological Sex* _____ **Hospital Sample ID** _____

Ancestry[1]

☐ European ☐ African American/Afro-Caribbean ☐ Sub-Saharan African ☐ Latino

☐ East Asian ☐ Central/South Asian ☐ Other _____

Sample ID
Internal use only

[1] As defined by the Clinical Pharmacogenetics Implementation Consortium (CPIC)

HEALTH PRACTITIONER DETAILS

Account ID* _____ **Address 1*** _____

Full Name* _____ **Address 2** _____

Phone* _____ **City/town*** _____

Email* _____ **County/ State*** _____

Institution* _____ **Post Code*** _____

Country* _____

TEST DETAILS

Gene to be analysed*[2]

☐ ***DPYD* gene variants**
(*2A (c.1905+1A>G), *13 (c.1679T>G), HapB3 (c.1236G>A) and c.2846A>T)

☐ ***TPMT* gene variants**
(*2 (c.238G>C), *3B (c.460G>A) and *3C (c.719A>G))

☐ ***CYP2C19* gene variants**
(*2, *3, *17)

[2] Please refer to our Laboratory User Guide for information on the sample requirements for this test.

CLINICAL INFORMATION

Referral Reason* _____

_____

_____

_____

SAMPLE DETAILS

Sample Type ☐ Whole Blood (EDTA Tube) ☐ Genomic DNA, **Source:** _____

Date Collected (DD/MM/YYY)* _____ **Time Collected (HH:MM)** _____

BILLING AND REPORT DETAILS

The invoice for this test will be sent to the default billing address associated with your Account ID. If your institution requires a PO number, please insert it here.

PO Number _____

The report for this test will be made available in your account on Genseq's online ordering portal. If you need other health practitioners to have access to the report, please ensure they are registered under your Account to ensure appropriate communication.

***Please, indicate how long you would like Genseq to store laboratory test raw data on your behalf:**

☐ **6 months** (default retention time where no option is chosen) ☐ **12 months**

In addition, in order to fulfil your instructions to perform the genetic testing undertaken in the context of an accredited genetic testing service, you understand that other data types, such as patient data received on this Test Request Form, laboratory QC data and report data will be stored for a further period of years taking account of applicable law, regulation and industry guidance. In returning this Test Request Form for processing you are instructing us in writing to undertake such processing on your behalf

☐ ***I hereby confirm that I have obtained written informed consent from the patient for this test to be performed, including consent for health practitioners registered under my account to access the report.**