Counsyl Abbott Pathology Genomic Diagnostics

Phone: 1800 822 999
Email: info@genomicdiagnostics.com.au
www. genomicdiagnostics.com.au

COUNSYL – FORESIGHT CARRIER SCREEN – TEST REQUEST FORM

Lab ID:

PATIENT INFORMATION

Last Name: .....

First Name: .....

Postal Address: .....

.....

Email: .....

Mobile No.: .....

DOB: D D M M Y Y Y Y Age: .....

Sex: ☐ Male ☐ Female

REQUESTING DOCTOR

Name: .....

Fax (Mandatory): .....

Phone: .....

Postal Address: .....

.....

Signature: .....

Provider No.: .....

COPY TO DOCTOR

Name: .....

Phone: .....

Fax: .....

Postal Address: .....

.....

COLLECTION INFORMATION

PLEASE SEND ALL REQUEST FORM PAGES WITH SAMPLE TO CENTRAL LAB.

PLEASE CONFIRM PATIENT HAS PAID FOR THIS TEST BY CHECKING THE RECEIPT BOX ON PAGE 2.

PERSON COLLECTING SPECIMEN TO COMPLETE:

I certify I established the identity of the patient named on this request, collected and immediately labelled the accompanying specimen with the patient's details.

Initials: ..... ACC Code / Location: .....

Date of draw: D D M M Y Y Time: ☐☐:☐☐ am/pm

THIS TEST REQUIRES PREPAYMENT – Please see over

DATA ENTRY INSTRUCTIONS

BILL CODE: COFS **PANEL CODE: CFC**

PATIENT ETHNICITY - TICK ONE BOX ONLY

☐ **Caucasian** (please specify from list below)
- ☐ Northern European (e.g. British, German, Irish)
- ☐ French Canadian or Cajun
- ☐ Ashkenazi Jewish
- ☐ Finnish
- ☐ Other / Mixed Caucasian

☐ **Asian** (please specify from list below)
- ☐ East Asian (e.g. Chinese, Korean, Japanese)
- ☐ South Asian (e.g. Indian, Pakistani)
- ☐ South-East Asian (e.g. Filipino, Vietnamese)

☐ **African or African American**
☐ **Hispanic**
☐ **Middle Eastern**
☐ **Pacific Islander**
☐ **Unknown**
☐ **Other**

CLINICAL INFORMATION

Is the patient above currently pregnant? ☐ Yes ☐ No

Gestational age: Weeks: ..... Days: .....

Do you wish to merge this patient with a partner? ☐ Yes ☐ No

A merged report will be provided that identifies combined carrier risk of the couple.

Partner Information:

First Name: .....

Last Name: .....

DOB: D D M M Y Y Y Y

Do not send to My Health Record ☐

SPECIMEN COLLECTION

Whole Blood: Draw 1 x 4mL whole blood into EDTA tube (lavender top)

COMMENTS (Please describe any relevant family history or prior testing)

REASON FOR TEST

- ☐ Family history
- ☐ High risk ethnicity
- ☐ Other genetic carrier status
- ☐ Supervision, other normal pregnancy
- ☐ Supervision, normal 1st pregnancy
- ☐ Consanguinity
- ☐ Screening for genetic disease carrier status
- ☐ Egg or sperm donor

To avoid delays: please ensure the Foresight Carrier Screen Payment/Consent forms are presented to the pathology collector at the time of attending sample collection.

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PAYMENT INFORMATION

Patient's Name: ..... DOB: ☐☐ ☐☐ ☐☐☐☐ Tel: ( ) .....

PATIENT AUTHORISATION: I understand this test requires prepayment of $879 per person tested before my blood is collected* ☐

PLEASE CALL 1800 822 999 TO PREPAY

Email Address (for receipt return): .....

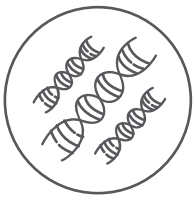
RECEIPT NO. ☐

* Pricing is valid at September 2018, pricing is subject to change without notice.

Informed Consent

Counsyl FORESIGHT CARRIER SCREEN

Please review this information carefully and then indicate with your signature if you wish to move forward with testing. This is a voluntary test. You may wish to seek genetic counseling prior to signing this form.



PURPOSE

- The Foresight Carrier Screen is designed to determine whether you carry genetic changes, called mutations, that could cause serious genetic conditions in your children.
- For most of the conditions on the panel, both parents must carry a mutation in the same gene for their children to be at risk of developing symptoms. However, there are certain conditions on the Foresight Carrier Screen for which only the mother needs to carry a mutation for her children to be at risk of developing symptoms.
- More information about each of the conditions on the Foresight Carrier Screen panel can be found at counsyl.com/foresight.

BENEFITS

- Your Foresight Carrier Screen results can help you and your partner make more informed decisions regarding your family, particularly if screening is performed prior to pregnancy.
- If it is early in your pregnancy, you can pursue further testing to determine if the pregnancy is affected, and receive guidance from your healthcare provider about how best to plan and prepare for birth.
- Your Foresight Carrier Screen results may also benefit your other family members. If you test positive, your biological relatives are more likely to test positive for the same mutation(s), thereby allowing them to discover previously unknown conditions and risks.

WHAT YOU MIGHT LEARN

- Carrier (Positive): A positive test result indicates that a mutation has been identified and that you are a carrier of the indicated condition. You may be identified as a carrier for more than one condition. Carriers usually do not experience symptoms of the condition.
- No mutations detected (Negative): A negative test result indicates that no gene mutations were identified. This reduces but does not eliminate the possibility of you being a carrier for a condition on the panel.

PROCEDURE

- The Foresight Carrier Screen can be done before pregnancy or early in pregnancy, as ordered by your healthcare provider.
- A small blood sample is taken and sent to Counsyl for screening.
- Except in rare cases, your sample will be kept a maximum of 180 days.*

RISKS

- Genetic testing may reveal sensitive information about your health and that of your family members.
- This test may provide information that can have an impact on your medical decisions.

LIMITATIONS

- The Foresight Carrier Screen is not intended to detect all genetic mutations.
- You and your healthcare provider together may decide which version of the Foresight Carrier Screen will be ordered for you. Your report will indicate which genes are included in your analysis and only variants in those genes requested will be reported.
- As with all medical screening tests, there is a chance of error, including a false positive or false negative result.
- A “false positive” refers to identifying a mutation that is not present.
- A “false negative” is the failure to detect a mutation that is present in the sample.
- Certain factors, such as having blood cancer, prior blood transfusions, or previous bone marrow transplants can affect the accuracy of Foresight Carrier Screen results. Be sure to discuss your medical history with your healthcare provider.
- Occasionally it may not be possible to provide a result. A repeat specimen may be requested.

PRIVACY

- If you and your partner are receiving simultaneous Foresight Carrier Screen testing, each of your test results may be revealed to one another and to each other’s ordering providers.
- Your Foresight Carrier Screen results will be reported to your healthcare provider or his/her agent.
- By agreeing to testing and signing this consent, you hereby authorise Genomic Diagnostics to share your Foresight Carrier Screen results with other authorised representatives that you’ve identified to us or your healthcare provider, or as otherwise allowed by law.
- Counsyl may find information that is not included in the original test requested by your healthcare provider and may report these additional results, if clinically relevant. You authorise Genomic Diagnostics to share these results with you and your healthcare provider.
- Please refer to Counsyl’s Notice of Privacy Policy, available on the Counsyl website, for additional information about Counsyl’s privacy practices, including how your protected health information (including your samples and genetic information) may be shared with third-party vendors and service providers that they partner with to provide testing services to you.
- Please refer to Genomic Diagnostics.

RESEARCH*

- Unless you contact us to request otherwise, by agreeing to testing and signing this consent, you authorise Counsyl and its partners to use your sample and any information derived from your sample or otherwise collected about you for educational and/or research purposes. You will not be compensated for this use.
- De-identified information may additionally be submitted to external research databases.
- You authorise Counsyl to contact you about potential educational and/or research opportunities.

☐ I wish to opt out of such research or future contact.

I have read or have had read to me and understand all of the above information and have had an opportunity to ask questions about the purpose, procedure, risks, benefits and limitations of testing.

I HAVE DECIDED TO PURSUE TESTING and to be bound by the terms of this Consent and any policies referenced herein.

Patient Name	Date of Birth	Patient Signature	Date

Ordering Healthcare Provider Name	Ordering Healthcare Provider Signature	Date

Abbott Pathology Genomic Diagnostics