ST VINCENT'S HOSPITAL MELBOURNE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

RCPA The Royal College of Pathologists of Australasia

NATA ACCREDITED FOR TECHNICAL COMPETENCE

MITOCHONDRIAL AND AUTOIMMUNE NEUROLOGICAL DISORDERS LABORATORY

ilac-MRA NATA
Accreditation No. 13786

5th Floor, Daly Wing, St Vincent's Hospital,
35 Victoria Pde, Fitzroy, Victoria, AUSTRALIA 3065
Tel (613)9231 3366 Fax (613)9231 3350

CONSENT FOR PAYMENT OF GENETIC TESTING

DATE:

TO:

Address:

We have received a request for testing for the following genetic disorder(s):

For patient: ……..

D.O.B.: ……..

UR and SVR No:…….

The TOTAL COST of the test(s) requested is:…$.....……(Note: we are NOT able to bulk bill)

Invoicing - please choose and provide information for one of the following three options:

☐ **1. Health institution/department to be invoiced**. (**Please be aware the department or hospital in which the test laboratory is located is not responsible for payment on the patient's behalf**).

Please advise us of the FULL contact name and FULL address of the person/department to whom the invoice for the testing should be sent to:

Name……..

Address…….....

OR

☐ **2. Patient to be invoiced (please be aware testing CANNOT be claimed through Medicare or Private Health Insurance)**. Please provide the patient's address and have them sign the consent below:

I (Name), ……..…….of (Address)……

consent to pay the total cost of the requested test(s) listed above.

Signed:……..Date:……/……/…….

OR

☐ **3. Please DO NOT proceed with testing**

Testing will not commence until this information has been received.

Please return via fax, email or post to

Dr. Rosetta Marotta
Fax: (+61) 3 9231 3350
Email: rosetta.marotta@svha.org.au
Address: 5th Floor Daly Wing,35 Victoria Pde Fitzroy Vic 3065