ST VINCENT'S HOSPITAL MELBOURNE
RCPA NATA
Accredited for compliance with NPAAC standards and ISO 15189
Accreditation No. 13786

Mitochondrial and Autoimmune Neurological Disorders Laboratory
5th Floor Daly Wing, St Vincent's Hospital
35 Victoria Pde, Fitzroy Victoria 3065
Tel: 03 9231 3366 Fax: 03 9231 3350

Information collected on this form is to determine the most appropriate mtDNA genetic tests.

Office use only
SVR No. _____ **Specimen No/s.**_____

Date: ____/____/____ **Time**_____:_____ **Staff Member** _____

Patient Information

Title | **Surname** | **First Name** | **M/F** | **Date of Birth**

Street | **Suburb** | **State** | **Postcode**

Country | **Telephone No.** | **UR No.**

Physician Information

Title | **Surname** | **First Name** | **Provider No.**

Hospital / Medical Centre/Clinic/Institution

Street | **Suburb** | **State** | **Postcode**

Country | **Telephone No.** | **Fax No.** | **E-mail address**

Specimen and Signed Consent for Genetic testing

Note: Testing cannot proceed without a signed consent and billing details

10-20	2 x 3 mls	20-50 mls	>50mg		
Hair follicles	**Blood (EDTA)**	**Urine 1st morning void**	**Muscle**	**Date taken**	**Date Sent**

Collection of two of more specimens are required for genetic testing.
All genetic testing to be accompanied by genetic counselling.

Genetic information obtained from these tests will be kept confidential and not released to anyone without prior patient permission. Does the patient consent to the testing of their DNA which may identify genetic variations (e.g. mutations) and may have implications for family members? **Yes No**

Does the patient consent to the non-identified use of their specimen/s for test quality assurance and validation activities and reports? **Yes No**

Signature:.....
(Patient/Next of Kin)

Billing Information

Genetic tests *do not* attract a Medicare or Private Health Care Rebate
(Please note no Item numbers for rebates)

MT-TL1 gene (m.3230-m.3304)(MELAS m.3243A>G, m.3271T>C)	**$210**
MT-TK gene (m.8295-m.8364)(MERRF m.8344A>G, m.356T>C)	**$210**
MT-ATP6 gene (m.8527-9207)(NARP/LS m.8993T>C/G, m.9176T>C)	**$210**
LHON Multiplex RFLP m.3460G>A, 11778G>A, m.14484T>C	**$210**
Sanger Sequencing per mtDNA gene	**$210**

Bill **(✓ / ✗)**
Patient
Hospital / Pathology / Medical Centre
Please complete the out of pocket billing consent form with authorization details of patient or institution.

Name:

Clinical Features - Check Boxes

Presenting Complaint:

Age of onset:

Symptoms	**Yes**	**No**	**N/A**
Development Delay			
Intellectual disability			
Exercise Intolerance			
Nausea/Vomiting			
GI Pseudoobstruction			
Headache/Migraine			
Stroke			
Episodic Coma			
Dementia			
Seizures			
Myoclonus			

Family History

Maternal
Sporadic
Autosomal dominant
Other please specify:

Imaging Studies-	**Norm**	**Abnorm**	**N/A**
Angiogram			
MRI			
SPECT			
CSF			
CT			
Basal Ganglia Calcification			

Clinical Features - Check Boxes

Signs	**Yes**	**No**	**N/A**
Short Stature			
Congestive Heart Failure			
Respiratory Insufficiency			
Diabetes Mellitus			
Hypothyroidism			
Hypoparathyroidism			
Optic Atrophy			
Ophthalmoplegia			
Ptosis			
Lipomas			
Retinopathy			
Cortical Blindness			
Cerebellar Signs			
Hearing Loss			
Proximal Limb Weakness			
Neuropathy			
Rhabdomyolysis			
Exercise related			
Spontaneous			

Laboratory Studies-	**Yes**	**No**	**N/A**
Elevated Blood Lactate			
Pyruvate			
CSF Protein			
ECG Heart Block			
Pre-excitation			
EMG/NCS Myopathic			
Neurogenic			

Other
(eg. Hisotopathology. Biochemistry)
please specify or attach report:

This form is not a referral slip for specimen collection.
Patients must have specimens collected at their nearest pathology collection centre.
This form must accompany the specimen/s to the laboratory for testing.