ST VINCENT'S HOSPITAL MELBOURNE
RCPA
NATA ACCREDITED FOR TECHNICAL COMPETENCE

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

ilac-MRA NATA
Accreditation No. 13786

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** X.....
(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)	$150	☐
MT-TK gene (m.8295-m.8364)(MERRF m.8344A>G, m.356T>C)	$150	☐
MT-ATP6 gene (m.8527-9207)(NARP/LS m.8993T>C/G, m.9176T>C)	$150	☐
LHON Multiplex RFLP m.3460G>A, 11778G>A, m.14484T>C	$150	☐
Sanger Sequencing per mtDNA gene	$150	☐
Southern Deletion screen	$400	☐

Bill (Tick or Cross)
Patient ☐
Hospital / Pathology / Medical Centre ☐

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.