

Office use only  
**SVR No.** \_\_\_\_\_ **Specimen No/s.** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Time** \_\_\_\_:\_\_\_\_ **Staff Member** \_\_\_\_\_

**Name:**

**Clinical Features - Check Boxes**

**Presenting Complaint:**

**Age of onset:**

<i>Symptoms</i>	Yes	No	N/A
Development Delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI Pseudoobstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache/Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Episodic Coma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myoclonus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### Family History

Maternal	<input type="checkbox"/>
Sporadic	<input type="checkbox"/>
Autosomal dominant	<input type="checkbox"/>
Other please specify:	


<b>Imaging Studies-</b>	Norm	Abnorm	N/A
<b>Angiogram</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>MRI</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SPECT</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CSF</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CT</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Basal Ganglia Calcification</b>	<input type="checkbox"/>	<input type="checkbox"/>	

**Clinical Features - Check Boxes**

**Signs** **Yes** **No** **N/A**

<b>Short Stature</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Congestive Heart Failure</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory Insufficiency</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Diabetes Mellitus</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hypothyroidism</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hypoparathyroidism</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Optic Atrophy</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ophthalmoplegia</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ptosis</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lipomas</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Retinopathy</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cortical Blindness</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cerebellar Signs</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hearing Loss</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Proximal Limb Weakness</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neuropathy</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Rhabdomyolysis</b>			
<b>Exercise related</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Spontaneous</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Laboratory Studies-</b>	Yes	No	N/A
<b>Elevated Blood Lactate</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pyruvate</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CSF Protein</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ECG Heart Block</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pre-excitation</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EMG/NCS Myopathic</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurogenic</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other</b> (eg. Hisotopathology. Biochemistry) please specify or attach report:			

Patient Information					
<b>Title</b>	<b>Surname</b>	<b>First Name</b>	<b>M/F</b>	<b>Date of Birth</b>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<b>Street</b>		<b>Suburb</b>	<b>State</b>	<b>Postcode</b>	
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	
<b>Country</b>	<b>Telephone No.</b>		<b>UR No.</b>		
<input type="text"/>	<input type="text"/>		<input type="text"/>		
Physician Information					
<b>Title</b>	<b>Surname</b>	<b>First Name</b>	<b>Provider No.</b>		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
<b>Hospital / Medical Centre/Clinic/Institution</b>					
<input type="text"/>					
<b>Street</b>	<b>Suburb</b>	<b>State</b>	<b>Postcode</b>		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
<b>Country</b>	<b>Telephone No.</b>	<b>Fax No.</b>	<b>E-mail address</b>		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Specimen and Signed Consent for Genetic testing					
<b>Note: Testing cannot proceed without a <u>signed consent</u> and <u>billing details</u></b>					
10-20	<input type="checkbox"/>	2 x 3 mls	<input type="checkbox"/>	20-50 mls	<input type="checkbox"/>
				>50mg	<input type="checkbox"/>
					<input type="checkbox"/>
<b>Hair follicles</b>	<b>Blood (EDTA)</b>	<b>Urine 1<sup>st</sup> morning void</b>	<b>Muscle</b>	<b>Date taken</b>	<b>Date Sent</b>
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? <b>Yes No</b>					
<input type="checkbox"/> <input type="checkbox"/>					
Does the patient consent to the non-identified use of their specimen/s for test quality assurance and validation activities and reports? <b>Yes No</b>					
<input type="checkbox"/> <input type="checkbox"/>  <b>Signature</b> ..... (Patient/Next of Kin)					
Billing Information					
<b>Genetic tests <u>do not</u> attract a Medicare or Private Health Care Rebate</b> (Please note no Item numbers for rebates)					
<b>MT-TL1 gene (m.3230-m.3304)(MELAS m.3243A&gt;G, m.3271T&gt;C)</b>	<b>\$240</b>	<input type="checkbox"/>	<b>Bill</b>	<b>( ✓ / * )</b>	
<b>MT-TK gene (m.8295-m.8364)(MERRF m.8344A&gt;G, m.356T&gt;C)</b>	<b>\$240</b>	<input type="checkbox"/>	<b>Patient</b>	<input type="checkbox"/>	
<b>MT-ATP6 gene (m.8527-9207)(NARP/LS m.8993T&gt;C/G, m.9176T&gt;C)</b>	<b>\$240</b>	<input type="checkbox"/>	<b>Hospital / Pathology / Medical Centre</b>	<input type="checkbox"/>	
<b>LHON Multiplex RFLP m.3460G&gt;A, 11778G&gt;A, m.14484T&gt;C</b>	<b>\$240</b>	<input type="checkbox"/>	Please complete the out of pocket billing consent form with authorization details of patient or institution.		
<b>Sanger Sequencing per mtDNA gene</b>	<b>\$240</b>	<input type="checkbox"/>			