



# Consent and Payment Form

(To be accompanied by a referral form)

## Patient Information

Surname:

First Name:

Date of Birth:

NHI:

Email address:

Contact number:

Requesting Clinician:

(Please print)

## Laboratory testing

The presence or absence of a specific gene mutation has been identified as a predictor of drug response. Testing for gene mutations prior to treatment ensures that the patient receives a drug that has the potential to work for them.

### \*\*\*Patient Consent\*\*\*

I understand that laboratory testing on my tissue is part of a clinical workup for my condition and the testing to be undertaken has been explained to me by the requesting clinician. I give permission for my tissue to be used for the following laboratory tests(s):

Melanoma panel

Lung Panel

Colorectal panel

Other (please state) : \_\_\_\_\_

\*\*\*Patient Signature\*\*\*:

Date:

## Payment Details (Samples will not be processed unless payment has been confirmed)

**Total \$483.00\* (inclusive of GST)**

**\*This is the current cost of testing for the panels listed above. Please contact the laboratory for the cost of any "other" tests required.**

### Internet Banking Details (Please use SURNAME and DOB as reference):

Bank: ASB

Account: IGENZ Ltd T/A DNA Diagnostics

Account details: 12-3109-0145960-00

### Website for secure online credit card payments:

<https://www.dnadiagnostics.co.nz/payment.php>

**Credit card payments can also be made via telephone by calling (09) 571 0474**

### Contact information:

IGENZ Ltd, L2, Quay Park Centre, 68 Beach Road, Auckland 1010

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