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 $494.50* (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:
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