# 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 $565.00* (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. Please mention that you are wanting to make payment for molecular testing.**

**Contact information:**
IGENZ Ltd, L2, Quay Park Centre, 68 Beach Road, Auckland 1010
PO Box 106542, Auckland 1143, New Zealand
T+64 9 307 3981 info@igenz.co.nz www.igenz.co.nz