VirtusGenetics
A MEMBER OF VIRTUS HEALTH

PGT Request Form
Pre-implantation Genetic Test

Ph: 1800 837 284

BARCODE

PATIENT INFORMATION:

Patient First Name:

Surname:

Date of Birth: _____ / _____ / _____ Sex:

Address:

Tel (Mobile):

Medicare No. ☐☐☐☐ ☐☐☐☐☐ ☐

Gamete source: Own ☐ Donor ☐ Donor code:

STATE THE PATIENT'S STATUS AT THE TIME OF THE SERVICE OR WHEN THE SPECIMEN WAS COLLECTED:

a private patient in a private hospital or approved day hospital facility	☐ Yes	☐ No
a private patient in a recognised hospital	☐ Yes	☐ No
a public patient in a recognised hospital	☐ Yes	☐ No
an outpatient of a recognised hospital	☐ Yes	☐ No

PARTNER INFORMATION: *(if applicable)*

First Name:

Surname:

Date of Birth: _____ / _____ / _____ Sex:

Address: ☐ (tick if same as patient)

Tel (Mobile):

Gamete source: Own ☐ Donor ☐ Donor code:

I consent for my information to be included on my partner's pre-implantation genetic testing reports.

Partner Signature:

Date:

TESTS REQUESTED:

	Meets MBS criteria*	
Karyomapping evaluation for pre-implantation genetic testing A separate request form is required for each partner. Out of pocket fees may apply.	YES ☐	NO ☐
OR		
Genetic analysis of embryonic tissue A single request form for the female partner is required. Out of pocket fees will apply.	YES ☐	NO ☐

**See overleaf for MBS clause 2.7.3A See Medicare Benefits Schedule for full details.*

CLINICAL INFORMATION:

Where available, please attach a copy of the clinical geneticist consultation letter to this request form.

☐ SD

REQUESTING DOCTOR:

Name:

Address:

Phone: Provider No:

I confirm that this patient been counselled about the purpose, scope, and limitations of the test and has provided informed consent for the test.

Doctor Signature:

Date:

COPY REPORTS TO:

Name:

Address:

FOR THE PATIENT:

I confirm that I have been informed about the purpose, scope, and limitations of the test (see overleaf). If I do not fulfil the Medicare criteria, or an out-of-pocket fee applies, I understand and consent to payment of fees. I understand that I will receive an SMS, email and/or invoice with my reference code for confirmation of test fees.

Medicare Agreement (Section 20A of the Health Insurance Act 1973):
I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner.

Patient signature:

Date:

Reason for patient being unable to sign *(practitioner use only)*:

FOR THE COLLECTOR:

I certify that I established the identity of the patient named on this request form and collected and immediately labelled the accompanying specimen(s) with the patient's name, DOB, and date/time of collection.

Please collect 1 x 4mL dedicated whole blood EDTA tube. Store sample at room temperature.

Collector name:

1 x 4mL EDTA ☐ Collection time: Date:

Collector signature:

Date:

VG25 PGT - 29.10.2021

Your doctor has recommended that you use Virtus Health Specialist Diagnostics, an Approved Pathology Authority. You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor.

RCPA The Royal College of Pathologists of Australasia NATA

Privacy note:

The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update enrolment records. Its collection is authorised by the provisions of the Health Insurance Act 1973. The information may be disclosed to the Department of Health or to a person in the medical practice associated with this claim, or as authorised/required by law.

Medicare rebate eligibility criteria:

Clause 2.7.3A

Items 73384 to 73387 (relating to pre-implantation genetic testing)—patient eligibility

A patient is eligible for a service described in any of items 73384 to 73387 only if:

(a) the patient or the patient's reproductive partner:

  (i) has an identified gene variant which places the patient at risk of having a pregnancy affected by a Mendelian or mitochondrial disorder; or

  (ii) is at risk of an autosomal dominant disorder which places the patient at risk of having a child who develops the autosomal dominant disorder; or

  (iii) has a chromosome re-arrangement or copy number variant which places the patient at risk of having a pregnancy affected by a chromosome disorder; and

(b) there is no curative treatment for the disorder and there is severe limitation of quality of life despite contemporary management of the disorder; and

(c) the patient has previously had a consultation, with a specialist or consultant physician practising as a clinical geneticist, that included a discussion about the disorder.

73384

Genetic analysis, for a patient who is eligible for this service under clause 2.7.3A, of samples from the patient and (if relevant) the patient's reproductive partner, for the purpose of providing an assay for pre-implantation genetic testing, requested by a specialist or consultant physician

Applicable not more than once per patient episode per disorder (of a kind described in clause 2.7.3A) per reproductive relationship

73385, 73386, 73387

Genetic analysis, for a patient who is eligible for this service under clause 2.7.3A, of embryonic tissue, if the analysis is:

(a) for the purpose of providing a pre-implantation genetic test; and

(b) requested by a specialist or consultant physician; and

(c) performed in the assisted reproductive treatment cycle in which the embryo was produced

Applicable not more than once per assisted reproductive treatment cycle