

**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 report.*

\_\_\_\_\_ **Partner signature:** \_\_\_\_\_

 \_\_\_\_\_ **Date:** \_\_\_\_\_

**CLINICAL INFORMATION:**

Where available, please provide a copy of the clinical geneticist consultation letter to aid in test interpretation.

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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.

**TESTS REQUESTED:**

|   | Meets MBS criteria*      |                          |
|---|--------------------------|--------------------------|
|   | YES                      | NO                       |
| <b>Karyomapping evaluation</b><br>Testing of blood specimens from a patient and their reproductive partner, for the purpose of providing a PGT assay. A separate request form is required for each individual having their specimen collected. This test is bulk billed for eligible patients.  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>OR</b>   |                          |                          |
| <b>Genetic analysis of embryonic tissue</b><br>Testing of embryonic tissue to determine risk of an embryo being affected by a known genetic condition. A single request form in the female partner's name is required. This test will be billed to the patient and eligible patients may claim a rebate from Medicare. This form may accompany embryo biopsies or be sent directly to the PGT laboratory. | <input type="checkbox"/> | <input type="checkbox"/> |

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

**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. 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 initials: \_\_\_\_\_ Location code: \_\_\_\_\_

1 x 4mL EDTA  Collection time: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ **Collector signature:** \_\_\_\_\_

 \_\_\_\_\_ **Date:** \_\_\_\_\_

## 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:

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### 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.
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### 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

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### 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

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Enquiries 1800 161 128

Email: [info@virtusgenetics.com.au](mailto:info@virtusgenetics.com.au)

Please send specimens to:

PGT Laboratory

Virtus Health Specialist Diagnostics

344 Victoria Parade, East Melbourne VIC 3002

[www.virtusgenetics.com.au](http://www.virtusgenetics.com.au)