preciselee

# **Familee Screen** Request Form

**Patient Details**

First Name _____

Surname _____

Date of Birth _____ Sex at Birth _____

Address _____

_____

Phone _____

Email _____

Medicare No. ☐☐☐☐☐☐☐☐☐☐

**Requesting Practitioner**

Name _____

Address _____

_____

Phone _____

Email _____

Provider No. _____

Doctor Signature _____ Request Date _____

Patient's status at time of service or specimen collection:

- ☐ A private patient in a private hospital or approved day hospital
- ☐ A private patient in a recognised hospital
- ☐ A public patient in a recognised hospital
- ☐ An outpatient of a recognised hospital

**Copy Reports To**

Name _____

Address _____

_____

***This screen is designed for pre-pregnancy planning and is not recommended during pregnancy***

**Tests Requested** | Scan QR code for more information

☐ Basic Carrier Screen
Screens for 3 common genetic conditions: cystic fibrosis, spinal muscular atrophy, fragile X syndrome

Indication:*

☐ Planning pregnancy

☐ Expanded Carrier Screen
Screens for 1000+ additional genetic conditions

☐ Personal Genetic Screen
Screens for 80+ genetic conditions that can affect your own health

☐ Chromosome Analysis
Screens for missing or extra DNA across your whole genome

Indication:*

☐ Expanded Carrier Screen and/or Personal Genetic Screen also requested

☐ Family history of intellectual disability, developmental delay, autism, and/or congenital anomalies

**Clinical Information** Eg. family history of genetic conditions

_____

_____

_____ ☐ SD

I confirm that I have been informed about the purpose, scope, and limitations of the tests requested.

**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.

**Financial Acknowledgement:**
I confirm that (a) if I do not qualify for an available Medicare rebate, I agree to pay the cost of the test in full; (b) I have been informed of the private fees for tests that do not attract a Medicare rebate and I agree to pay these fees; and (c) I may be charged a cancellation fee if I decide not to proceed with testing.

**Patient Signature** _____ **Date** _____

**Practitioner's Use Only (Reason patient cannot sign)**

_____

**Patient Checklist**

- ☐ Complete online pre-test counselling (mandatory)
- ☐ If you did not receive a saliva collection kit from your doctor, email a clear photo or scanned copy of your signed request form to contact@preciselee.co

**Scan QR code for more information**

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 and Aged Care or to a person in the medical practice associated with this claim, or as authorised/required by law.

Your doctor has recommended that you use Preciselee, 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.