SYDNEY SOUTH WEST PATHOLOGY SERVICE (SSWPS) Concord Repatriation General Hospital CONCORD NSW 2139	**Molecular Medicine Laboratory** **Clinical Sciences Building** **Tel: +61-2-9767 7009 Fax: +61-2-9767 6194** Garth A. Nicholson MBBS PhD FRACP Professor of Neurogenetics Provider No: 298133K Stephen Reddel MBBS PhD FRACP Staff Specialist Neurology Provider No: 202085DY

SERVICE REQUEST FOR DNA ANALYSIS: SEND WITH BLOOD SAMPLE

SERVICE DETAILS: Please see http://www.sswahs.nsw.gov.au/sswps/ for details of tests.

Please indicate: DIAGNOSTIC TESTING [ ] OR PREDICTIVE TESTING* [ ]. *Genetic counselling is required for all predictive testing. See http://www.health.nsw.gov.au/archive/cib/circulars/2003/cir2003-25.pdf for guidelines. Predictive testing will not be commenced without the signed consent, and two separate samples taken on separate occasions are required.

Test requested:

Clinical information:

Family history & predicted mode of inheritance:

Other family members tested (Name and DOB):

The following tests are available:
Neuropathy (please attach NCS): CMT1A / HNPP (PMP22), MPZ, CMT2A (MFN2), CMTX1 (GJB1/Connexin 32), HSN1(SPTLC1, SPTLC2). FOLLOWING DISCUSSION ONLY: RAB7, NEFL, GDAP1, BSCL2, PGK1.
Motor Neuron Disease: SOD1, Kennedy's (AR), TARDBP, C9ORF72.
Ataxia: Spinocerebellar Ataxia Type 1, 2, 3, 6, 7, 12, 17, either as a single SCA from a known family or as a whole set of screen. DRPLA, Friedreich's Ataxia.
Muscle: Myotonic Dystrophy Type 1(DM1), Myotonic Dystrophy Type 2 (DM2), Facioscapulohumeral Muscular Dystrophy (FSHD).
Others: Familial Parkinson's Disease, LRRK2, SNCA. Hereditary Spastic Paraplegia (SPG4, SPG3A and SPG31).

Please note that all these tests are very expensive for your patient and discussion with the readily available laboratory staff about which test/s is/are appropriate, and the likelihood of a positive result, is often worthwhile.

Patient consent:
Has a **Consent Form for Specialised/DNA Testing** been completed □ Yes □ No

I give permission for my sample to be stored indefinitely and to be used for testing additional relevant gene testing in collaborating laboratories.

Patient signature…… Interpreter if used……..Date ……

Patient First Names: Patient Surname: DOB: SEX: Address: Contact Ph:	Doctor: Provider No: Address: Contact Ph: Sign & Date:

SEND TO:	**BLOOD COLLECTION:**
MOLECULAR MEDICINE LABORATORY, **CLINICAL SCIENCES BUILDING** **CONCORD HOSPITAL, NSW 2139, AUSTRALIA** **Laboratory contact Ph: 02 97677009**	• **EDTA TUBES** • Collect 5-10 mls,(babies minimum 1ml) • Mix by gentle inversion for several minutes • Transport **AT ROOM TEMPERATURE** • Must take less than 48 hours in transit.