FORENSIC GENOMICS
INNOVATION HUB

# Pharmacogenomics Test Request Form

**Patient Details:**

**First name:**

**Date of birth:** DD MM YYYY

**Surname:**

**Gender:**

**Address:**

**Postcode:**

**Contact number:**

**Email address:**

**Current medication:**

(Please detail all prescription and over the counter medication), including daily dosage:

**If not on any medication, and test is for future potential medication planning, tick here:**

**Referring Doctor / Clinical Pharmacist details:**

Name:

Practice:

Address:

Phone:

Email:

I hereby confirm that I support the patient's decision to undergo a pharmacogenomics test to investigate their metabolic response to certain medications and will counsel the patient upon receipt of the report regarding any actionable changes to their medication.

**Signature:**

**Date:**

**Patient Informed Consent Declaration:**

I understand that this pharmacogenomics test will provide me with information on how my body will metabolise certain medications and will assist my medical practitioner in the choice of medicine prescribed for me now and in the future. I understand that this test does not look at all possible genetic causes of drug reactions or allergy mediated responses. This test report must be used in conjunction with my medical information and history when considering medications and any changes to current medications. I will NOT adjust my dosage of, or stop taking, any current medications, based on my own interpretation of the report.

**Name:**

**Signature:**

**Date:**

AFFIX BARCODE HERE

Lab use only:

Date received:

Time received:

DNA extraction date: