**Patient Consent for Non-Rebateable Test(s)**

I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**, understand that my doctor has requested test(s)

that are not covered by Medicare:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**­­­­­­­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(insert name of test).

I understand that I will receive an invoice from the Pathology Service for this test, and that this may not be the laboratory service where my blood/tissue was collected.

I agree to accept responsibility for the full payment of the fees for the test(s) that are not rebated by Medicare.

­­­­­­­­­­­­­­Patient Name Signature Date

**OR**

**The requesting department will cover the cost of this test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Insert name of test)

Department Name Cost Centre

Head of Department Name Signature Date

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient UR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Collection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Episode number (If known): ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­**

**Amount (Estimate): $AUD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Non-Rebateable Test (Indicative Costs):**

|  |  |  |
| --- | --- | --- |
| **Code** | **Test Name** | **Cost** |
| **CHRA** | **Chromogranin A** | **$38.50** |
| **AMH** | **Anti-Müllerian Hormone** | **$60.25** |
| **NMDA** | **n-methyl-d aspartate receptor Ab** | **$100.00** |
| **VGKC** | **Voltage Gated Potassium Channels** | **$100.00** |
| **MuSK Ab** | **Muscle Specific Kinase Antibody** | **$80.00** |
| **INHB.** | **Inhibin B** | **$82.00** |
| **METP** | **Plasma Metabolic/ Amino Acid Screen** | **$130.00** |
| **METU** | **Urine Metabolic Screen** | **$160.25** |
| **GUTH** | **Acyl carnitine** | **$110.25** |
|  | **HMG-CoA Reductase (3-hydroxy-3-methylglutaryl-coenzyme A Reductase) Antibodies** | **$80.00** |
| **ADAMTS** | **Routine ADAMTS-13 Activity** | **$140.00** |
| **ZnT8 Ab** | **Zinc Transporter 8 Antibodies** | **$40.00** |
|  | **Hereditary Amyloidosis – All genes (TTR/FGA/APOA1/LYZ)** | **$800.00** |
|  | **Hereditary Amyloidosis – Single gene: TTR** | **$400.00** |
|  | **Hereditary Amyloidosis – Single gene: FGA** | **$250.00** |
|  | **Hereditary Amyloidosis – Single gene: APOA1 or LYZ** | **$300.00** |
|  | **Telomere Length (The Children’s Hospital at Westmead)****(Must complete requisition and service agreement form from service provider)** | **$500.00** |
|  | **Cytochrome P450 Comprehensive Gene Panel** | **$190.00** |
|  | **Single gene from above panel (CYP2D6, CYP2C9, CYP2C19, CYP3A4, CYP3A5, CYP1A2, SLCO1B1 and VKORC1), or DPYD** | **$140** |
|  | **IGF-BP3** |  |
|  | **Co-peptin** | **$50.00** |
|  | **ROMA or HE4** | **$68.00** |
|  | **Soluble CD25** |  |
|  | **Carbohydrate deficient transferrin** | **$150** |
|  | **Pre-Eclampsia Markers (Non EH patients only)** | **$100** |
|  | **Faecal Calprotectin**  | **$60** |
| **Other:** |  | **$** |

**Every effort has been made toward the accuracy of this list, however referral labs can change their prices without notice, and this list should be considered indicative only. Some referral labs also charge a processing fee, usually less than $10.00.**