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

I understand that my doctor has requested test(s) that are not covered by Medicare.

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 was collected.

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

­­­­­­­­­­­­­­Patient Name Signature Date

**OR**

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

Department Name

Head of Department Name Signature Date

**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** | **$70.00** |
| **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** | **$40.00** |
|  | **Pyruvate (LiHep Plasma)** |  |
| **Other:** |  | **$** |

**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.**

he department will cover the cost of this test:s and thus a TSH only has been performed.22222222222222222222222222222222222222Departme