



Consent and Payment Form

(To be accompanied by a referral form)

Patient Information

Surname: _____ First Name: _____

Date of Birth: _____ NHI: _____

Email address: _____ Contact number: _____

Requesting Clinician:
(Please print)

Laboratory testing

The presence or absence of a specific gene mutation has been identified as a predictor of drug response. Testing for gene mutations prior to treatment ensures that the patient receives a drug that has the potential to work for them.

Patient Consent

I understand that laboratory testing on my tissue is part of a clinical workup for my condition and the testing to be undertaken has been explained to me by the requesting clinician. I give permission for my tissue to be used for the following laboratory tests(s):

Melanoma panel Lung Panel Colorectal panel

Other (please state) : _____

Patient Signature:

Date:

Payment Required* (Samples will not be processed unless payment has been confirmed)

Melanoma panel \$857.61

Lung Panel \$742.61

Colorectal panel \$742.61

***This is the current cost of testing for the panels listed above ONLY. Please contact the laboratory for the cost of any "other" tests required.**

Internet Banking Details (Please use SURNAME and DOB as reference):

Bank: ASB

Account: IGENZ Ltd

Account details: 12-3109-0145960-00

Website for secure online credit card payments:

<https://www.igenz.co.nz/payment-details/payment/>

Credit card payments can also be made via telephone by calling (09) 571 0474. Please mention that you are wanting to make payment for molecular testing.

Contact information:

IGENZ Ltd, L2, Quay Park Centre, 68 Beach Road, Auckland 1010

PO Box 106542, Auckland 1143, New Zealand

T+64 9 307 3981 info@igenz.co.nz www.igenz.co.nz