Payment authorisation

PATIENT DETAILS

LAST NAME:.....

GIVEN NAMES:.....

DOB:.....

UR/GF#:.....

VCGS LAB # (if known):.....

PARENTS/PARTNER/OTHER TO BE TESTED

	1.	2.
LAST NAME:	.....	.....
GIVEN NAMES:	.....	.....
DOB:	.....	.....
UR/GF #:	.....	.....
VCGS LAB # (if known):	.....	.....

VCGS TEST

Requesting consultant:.....

Test requested:.....

Test fee:.....

SEND INVOICE TO: ☐ VCGS ☐ PATIENT ☐ OTHER

NAME AND ADDRESS:

PAYMENT AGREEMENT/AUTHORISATION

☐ VCGS

☐ PATIENT/GUARDIAN FULL PAYMENT

☐ OTHER HEALTH SERVICE .....

I agree to pay all associated costs as detailed above.

Name:..... Cost:.....

Signed:..... Date:.....

Phone/mobile:.....

This completed form must be submitted to the laboratory together with the pathology request form and specimen.

VCGS
leaders in genetic health

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The Royal Children's Hospital
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