AMPATH LABORATORIES

PR0520005200431

DRS DU BUISSON, KRAMER, SWART, BOUWER INC.

REFERRING DOCTOR	
COPY DOCTOR	

PLACE BARCODE HERE

CLINICAL DIAGNOSIS/ MEDICATION		MEDICAL AID	PLAN
		MEDICAL AID NO.	DEP. CODE
ICD-10 CODES		MEDICAL AID AUTH.	STAT / ROUTINE

PATIENT DETAILS

ID NUMBER			
SURNAME		TITLE	
INITIALS & FIRST NAME		AGE	
DATE OF BIRTH	D D M M Y Y Y Y	SEX ASSIGNED AT BIRTH	M F
HOSPITAL/ FOLIO NO.			
CELL	(H)		
(W)			
EMAIL			

PERSON RESPONSIBLE FOR ACCOUNT (GUARANTOR)

GUARANTOR ID NUMBER			
SURNAME			
INITIALS & FIRST NAME		TITLE	
POSTAL ADDRESS			
		POSTAL CODE	
CELL	(H)		
(W)			
EMAIL			

PATIENT/GUARDIAN SIGNATURES:
I confirm acceptance of the informed consent available at ampath.co.za. Y N
I verify that all personal information is correct.

GUARANTOR'S SIGNATURE:
I consent to the requested tests and guarantee payment thereof.
I consent that ICD10 codes may be provided to my medical aid as per statutory requirements on my account. Y N

PHLEBOTOMY SITE	COLL. DATE	D D M M Y Y Y Y	FASTING Y N	PREGNANT Y N	REC. DATE	D D M M Y Y Y Y
	COLL. TIME		THYROID MEDICATION Y N	ON ANTI COAGULANT Y N	REC. TIME	
	COLL. BY				REC. BY	

HOSPITAL PATIENT Y N	NO OF TUBES DRAWN	S01	S02	E01	E02	HEP	CIT	FLU	MICRO / OTHER		TEST COUNT

PERSONALISED MEDICATION TEST

☐ **Pharmacogenomics** **PHARMA**

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PLACE BARCODE HERE

INFORMED CONSENT FOR PHARMACOGENETIC (PGx) TESTING

I, _____ or, if applicable, _____ lawfully representing

_____, who is a child younger than 12 years old or an individual lacking sufficient mental

capacity to understand the pharmacogenetic test, hereby acknowledge and consent to the following:

1. Purpose of Genetic Testing: I understand that I/the patient will be undergoing a pharmacogenetic test to assess how my/the patient's genetic makeup may influence my/their response to certain medications. This test aims to provide clinical decision support to healthcare professionals involved in my/the patient's care.

2. Specimen Collection: I confirm that I have/the patient has carefully followed the specimen collection instructions provided in the specimen collection kit to the best of my/their abilities (if applicable) and consent that the specimen obtained can be used for the purpose referred to in clauses 1 and 3.

3. Data Transmission to GenXys Health Care Systems Inc: I acknowledge that the genetic results of the pharmacogenetic test, as well as my/the patient's personal health information, will be transmitted to GenXys based in Canada. I understand that Canandian data protection legislation is similar to the South African Protection of Personal Information Act 4 of 2013 ("POPIA") and that GenXys has sufficient Information Technology standards in place to safeguard and protect my/the patient's personal information, as required by section 72 of POPIA. This information will only be used for the purpose referred to in clause 1. I understand that GenXys will not de-identify my/the patient's health information/genetics data but may not use it for any other commercial application, unless I/the patient grant explicit consent.

4. Confidentiality: I understand that my/the patient's genetic and personal health information will be handled with the utmost confidentiality. Only authorised personnel will have access to this information, and it will be used exclusively for the intended purpose. GenXys is subject to similar health data privacy regulations (PIPEDA, GDPR & HIPAA) as South Africa's: Protection of Personal Information Act 4 of 2013, National Health Act 61 of 2003, Health Professions Act 56 of 1974, Promotion of Access to Information 2 of 2000 and Children's Act 38 of 2005.

5. Potential Risks: I am aware that, while all efforts will be made to maintain the security of my/the patient's information, a potential risk of unauthorised access or data breaches still remains. GenXys has implemented measures to minimise these risks and will comply with the conditions of Chapter 3 of POPIA in order to lawfully process and protect my/the patient's personal information.

6. Right to Withdraw Consent: I understand that I have/the patient has the right to withdraw my/the patient's consent at any time before the test results are transmitted to GenXys without affecting my/the patient's current or future medical care.

7. Questions and Clarifications: I have/the patient has had the opportunity to ask questions and seek clarification regarding the genetic testing process and purpose of this testing, and all my/the patient's queries have been addressed satisfactorily.

8. National Health Act 61 of 2003: I confirm that my/the patient's physician and Drs Du Buisson, Kramer, Swart, Bouwer Incorporated have informed me/the patient of my/their rights in terms of section 6 of the National Health Act 61 of 2003.

I/the patient voluntarily consent to undergo the pharmacogenetic test and agree to the transmission of my/the patient's genetic and personal health information to GenXys, for the specified purposes.

Patient's Signature: _____ **Date:** _____

or (if applicable)

Full names and surname of patient: _____

Full names and surname of patient's representative: _____

Relationship to patient: _____

Signature of patient's representative: _____ **Date:** _____