

Patient Eligibility for Medicare Rebate: Haemochromatosis (HFE) Gene Mutation

Attention Patient:

- 1) Please ask your Doctor to complete this form.
- 2) Please return the completed form to the QML Pathology Clinic you attended.

Attach Lab no. here

office use only

Haemochromatosis Testing

In order to obtain a Medicare rebate, the answer to at least one of the following questions must be YES. If the answers to ALL questions are NO, then the patient will not be eligible for a Medicare rebate.

- | | | | |
|-----------|---|------------------------------|-----------------------------|
| 1. | Does the patient have a personal history of at least two elevated ferritin OR two elevated transferrin saturation levels? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. | Does the patient have a personal history of Haemochromatosis? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. | Does the patient's immediate family member have Haemochromatosis?
Please specify relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Siblings <input type="checkbox"/> Children | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. | Does the patient's immediate family member carry a homozygous HFE mutation?
Please specify relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Siblings <input type="checkbox"/> Children | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. | Does the patient's immediate family member carry a compound HFE mutation?
Please specify relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Siblings <input type="checkbox"/> Children | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Doctor Name _____ Doctor Signature _____ Date _____

Patient to Complete and Sign

I _____ (full name) understand that if I am not eligible for a Medicare rebate, then QML Pathology will issue an account to me of up to and including \$173.25* depending on testing requirements as referred by my Medical Practitioner. I accept that I will pay such monies owed to QML Pathology.

Patient Signature _____ Date of Birth _____ Date _____

*Price is correct at time of printing (September 2011) and is subject to change without notice.

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