PGx

Pharmacogenomic Testing
Intake Questionnaire

PATIENT DETAILS

First Name		**Last Name**	
Height (cm)		**Weight (kg)**	*Optional
Ethnicity		**Sex at Birth**	
DOB		**Phone Number**	( )
Email			

This pharmacogenomic report will be sent to your nominated doctor/psychiatrist. An email will be sent to you informing you when your test results have been sent to your nominated doctor/psychiatrist. You will be required to schedule an appointment with your doctor/psychiatrist to discuss your results.

YOUR NOMINATED GENERAL PRACTITIONER (GP)/ PSYCHIATRIST DETAILS

GP/ Psychiatrist Full Name		**Phone Number**	( )
Practice Name			
Practice Address		**State**	
Email		**Postcode**	

☐ Check this box if you do not currently have a GP or psychiatrist and would like us to arrange a consultation for you. Please note that this service will incur additional fees.

MEDICATIONS

Medications under consideration / for testing	
Medications not tolerated	

List of all medications (current and past) tick all that apply:

- ☐ Tricyclic antidepressants (e.g. desipramine, clomipramine)
- ☐ Mood stabilisers
- ☐ Benzodiazepines
- ☐ SSRIs (e.g. sertraline, escitalopram)
- ☐ MAOIs (e.g. phenelzine)
- ☐ Stimulants (e.g. lisdexamfetamine)
- ☐ Ketamine or esketamine
- ☐ SNRIs (e.g. venlafaxine, desvenlafaxine)
- ☐ Antipsychotics (e.g. paliperidone)
- ☐ Non-stimulant ADHD medications (e.g. atomoxetine)
- ☐ None
- ☐ Other (please specify): _____

PHARMACOLOGICAL & LIFESTYLE FACTORS

Caffeine Intake	☐ Mild ☐ Heavy ☐ None
Nicotine / Vaping	☐ Yes - packs/day: _____ ☐ No
Alcohol Intake	☐ Light ☐ Moderate ☐ Heavy ☐ None
Recreational Substances	☐ Cannabis ☐ Stimulants ☐ Opioids ☐ Psychedelics or dissociatives ☐ Other _____ ☐ None
Hormone Therapy	☐ Yes ☐ No

BIOLOGICAL FACTORS

Do you have a history of any of the following? — tick all that apply:

- ☐ Cardiovascular disease
- ☐ Autoimmune or inflammatory disease
- ☐ Sleep disorders
- ☐ Liver disease
- ☐ Epilepsy or seizures
- ☐ Hormonal conditions (incl. peri/menopause)
- ☐ Kidney disease
- ☐ Thyroid disorder
- ☐ Chronic pain
- ☐ Neurodevelopmental conditions (Intellectual disability/ ASD / motor disorder)
- ☐ Head injury / traumatic brain injury / neurosurgery
- ☐ Other (please specify): _____
- ☐ None

CONSENT: by signing this form you acknowledge each of the following

Purpose of pharmacogenomic testing. I understand that pharmacogenomic (PGx) testing is performed to assess how my genetic profile may influence my response to medicines. The purpose of this testing is to support safe and effective prescribing by providing my treating clinician with a clinical pharmacogenomic report that may inform medication selection and dosing.

Collection and analysis of genetic material. I consent to Thompson Brain and Mind Healthcare (TBMH), a not-for-profit organisation, collecting and analysing my biological sample (for example, saliva, buccal swab, or blood) for pharmacogenomic testing. Testing may be conducted by TBMH or by partner laboratories accredited by the National Association of Testing Authorities (NATA) and operating in accordance with relevant ISO standards, including ISO 15189 for medical laboratory quality and competence.

Clinical use of results. I understand that the results of my PGx test will be used to inform diagnosis, treatment, pharmacogenomics, and continuity of care. The testing supports, but does not replace, clinical judgement, and all treatment decisions remain the responsibility of my healthcare provider.

Storage of samples and genetic data. I understand that TBMH securely stores all biological samples and genetic data for only as long as reasonably necessary, which may be up to ten years, or as otherwise required by law or laboratory accreditation standards. Storage and handling will comply with the Privacy Act 1988 (Cth), the Australian Privacy Principles (APPs), and applicable NATA and ISO requirements.

Re-use for quality assurance and method development. I consent to my de-identified genetic material or data being used for quality assurance, validation, and method development activities necessary to maintain laboratory accuracy, safety, and accreditation. These activities will not involve the use of identifiable information.

Privacy and confidentiality. I understand that my personal and genetic information will be handled securely and confidentially in accordance with the Privacy Act and the APPs. Access to identifiable information will be restricted to authorised personnel only. De-identified data may be shared with approved collaborators or used in research and publications where I cannot be identified.

Voluntary participation and withdrawal. I acknowledge that participation in PGx testing is voluntary. I may withdraw my consent at any time before analysis has commenced, without affecting my access to care. If I withdraw after analysis has occurred, my stored sample may be destroyed upon request unless it must be retained for regulatory or accreditation purposes.

Risks and limitations. I understand that PGx testing may not identify all genetic factors and that some results may have limited or uncertain clinical significance. PGx testing does not diagnose medical conditions, predict all treatment outcomes, or guarantee therapeutic benefit.

Indemnification. By providing this consent, I release and indemnify TBMH, its employees, contractors and agents, affiliated laboratories, and research partners from liability arising from the interpretation or use of my pharmacogenomic results. I acknowledge that responsibility for applying the results rests with my treating clinician.

CONSENT: tick each box (consent or do not consent)

Secondary research use. I consent to my de-identified genetic data being used in ethically approved research projects overseen by the appropriate Human Research Ethics Committee (HREC), in accordance with the National Statement on Ethical Conduct in Human Research.	☐ **I consent** ☐ **I do not consent**
Data linkage. I consent to the linkage of my de-identified PGx data with other health or clinical datasets held by TBMH or collaborating institutions, for the purposes of HREC-approved research or service evaluation. Data linkage may involve collaboration with external institutions, including those located outside Australia. Reasonable steps will be taken to ensure any overseas disclosures comply with the Privacy Act and APPs.	☐ **I consent** ☐ **I do not consent**
Incidental findings. I understand that PGx testing is targeted to genes relevant to treatment response and is not designed to identify unrelated genetic conditions. If a clinically significant incidental finding is identified, such findings will only be reviewed and disclosed where ethically approved, clinically actionable, and appropriate. I consent to being informed of clinically actionable incidental findings that may have implications for my health.	☐ **I consent** ☐ **I do not consent**

Children and young persons. Where consent relates to a child or young person, TBMH will act in the best interests of the child. Consent will be obtained from a parent or legal guardian, unless the child is assessed as having sufficient maturity and understanding to provide informed consent as a mature minor, consistent with applicable law and professional standards.

Consent declaration. I, _____ (full name), as the person accessing treatment / parent / guardian, hereby acknowledge agreement to the above and confirm that I have read and understood this consent document. I have had the opportunity to ask questions and receive satisfactory answers. I provide this consent freely and without coercion.

Signature	*Date*	*Full Name (please print)*

We place the highest importance on protecting the privacy and personal information of people seeking support and treatment at Brain & Mind Hub Sunshine Coast, as well as the privacy of their support people. Comprehensive measures are in place to ensure the security of your personal information; the full Privacy Policy is at https://tbmh.org.au/privacy-policy

OFFICE USE ONLY:

Client ID		**BMI**	
Swab ID		**Provider Number**	