



Grafton Clinical Genomics

CYP2C19 MassArray Test Request Form

Requesting Doctor:	
Name:	_____
Address:	_____ _____
Contact no.:	_____ _____ _____

Patient Information:	
NHI #	_____
Date of Birth:	_____
Name:	_____
Sample ID:	_____
Sample date/Time:	_____
Sample Type:	_____

Test Requested	
CYP2C19 Genotype Analysis	<input type="checkbox"/>

<p>Note: Optimal sample for testing is a 5mL EDTA whole blood sample.</p>
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Name (Printed): _____	Signature and date: _____
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For GCG use: _____ Sample received date and time: _____

Send samples to: Grafton Clinical Genomics, Building no. 503-201, The University of Auckland, 85 Park Rd, Grafton, Auckland 1023
Contact: Purvi Kakadiya, p.kakadiya@auckland.ac.nz, gcgenomics@auckland.ac.nz, ph. +64 9 923 3432 (office)