TEST REQUEST FORM, ONCO/Reveal™ HRD Panel Assay

PATIENT INFORMATION		REQUESTING PHYSICIAN INFORMATION	
Family Name:	Sex:	Full Name:	
Given Name:		Phone:	
Reference/Medical Record Number:		Email:	
Date of Birth (DD / MM / YYYY):		Fax:	
Address:		Address:	
City:	Post Code:	City:	Post Code:

STICKER

STAMP

Copy reports to: *(Please add genetic counsellor or other physician details if desired)*

Full Name:	
Email:	
Fax:	Date:

TEST(S) REQUESTED

☐ ***ONCO/Reveal™ HRD Panel Assay*** (Testing of 27 genes involved in homologous recombination DNA repair. The list of genes can be obtained upon request.)

Cost: AUD1000 for tumour and paired blood samples (Medicare rebate not available)

☐ ***BRCA1 methylation*** (Qualitative determination of methylation of BRCA1 promoter; test performed by external accredited lab)

Cost: AUD400 for tumour sample (Medicare rebate not available)

☐ ***RAD51C methylation*** (Qualitative determination of methylation of RAD51C promoter; test performed by external accredited lab)

Cost: AUD500 for tumour sample (Medicare rebate not available)

CLINICAL DETAILS

Diagnosis & Stage:			
Treatment: (Tick all that apply)	☐ Surgery	☐ Radiation	☐ Chemotherapy
Specimen Site:			
Date of Collection:			
Peripheral Whole Blood:	☐ YES	☐ NO	
Blood Collection Site:	☐ Pathology Collection Centre	☐ Doctor's Office	

PERSON COLLECTING SPECIMEN TO COMPLETE BELOW:

I certify I established the identity of the patient named on this request, collected and immediately labelled the accompanying specimen(s) with the patient details.	Name:	Signature:

Family History of Cancer *(check one)*

☐ No Family History ☐ Unknown ☐ Family History

Details of family history:

Holding Laboratory Details (PLEASE INCLUDE PATIENT HISTOLOGY REPORT WITH TEST REQUEST FORM)

Laboratory Name:	
Address:	
Phone:	Fax:
Lab Reference ID:	☐ Patient Histology Report Attached

NOTE: 10 x 10um unstained sections plus one adjacent H&E-stained section are PREFERRED.

ONCE COMPLETED attach this form to patient histology report and send all to XING CANCER CARE

TEST AUTHORISATION AND CONSENT

My signature certifies that this test information will inform the patient's ongoing treatment plan and certifies that I am the patient's treating physician. I have explained to the patient the nature and purpose of the testing to be performed and have obtained informed consent to permit XING Cancer Care to perform the testing specified herein.

Treating Physician Name:	Treating Physician Signature:	Date:

IMPORTANT: Please note testing will not commence BEFORE payment information is received. To optimise the accuracy of test result interpretation and avoid delays, please complete the entire form.