

## Molecular Oncology Test Request Form





Form: ANAT-MOL-F-201 v12 ACCREDITED LABORATORY NUMBER: 2531

| PATIENT DETAILS (IN BLOCK LETTER)   | TESTS REQUESTED  |
|---|--|
| Family Name:  | (Note: Bulk billing tests for eligible patients are marked with $^{f *}$ )   |
| Given Name:   | LUNG CANCER (NSCLC)  |
| Address:  | Next Generation Sequencing (NGS)   |
| Postcode:   | ☐ NGS lung DNA panel (Medicare item: 73337)* \$397.35* (NGS panel including EGFR, KRAS & BRAF)   |
| DOB:/   | ☐ NGS <b>EGFR T790M</b> DNA panel (Medicare item: 73351)* <b>\$ 397.35</b> *   |
| Contact Phone No.:  | ☐ NGS lung RNA fusion panel \$ 356.00 (Selected ALK, NTRK1, RET & ROS1 fusions)  |
| DEGLIFOTING DDA GTITIQUED (IN DI GOLL ETTED)  | Immunohistochemistry (IHC)   |
| REQUESTING PRACTITIONER (IN BLOCK LETTER)   | ALK IHC (Medicare item: 72846)* \$ 59.60*  |
| Family name:  | ROS1 IHC (Medicare item: 72846)* \$59.60*  |
| Given Name:   | ☐ PD-L1 IHC (Medicare item: 72814)* \$ 74.50*  |
| Address:  | Perform relevant FISH if IHC is positive   |
| Postcode:   | Fluorescence In Situ Hybridisation (FISH)  ALK FISH (Medicare item: 73341)*  \$ 400.00*  |
| Provider No.:   | ☐ ROS1 FISH (Medicare item: 73344)* \$400.00*  |
| Phone: Fax:   | □ RET FISH \$400.00  |
|   | COLORECTAL CANCER  |
| Email (Required):   | ☐ NGS colorectal DNA panel (Medicare item:73338)* \$ 362.60*   |
|   | (NGS panel including KRAS, NRAS & BRAF)  |
| CLINICAL HISTORY  | MELANOMA   |
|   | ☐ NGS melanoma DNA panel (Medicare item: 73336)* \$230.95*   |
| HOSPITAL STATUS OF PATIENT AT SPECIMEN COLLECTION   | (NGS panel including BRAF, NRAS, GNAQ & GNA11)   |
| OR DATE OF SERVICE  | NEURO-ONCOLOGY  ☐ NGS IDH1/IDH2 DNA panel (Medicare item: 73372)* \$ 340.00  |
| Private patient in private hospital or approved day hospital facility   | ☐ 1p/19q FISH (Medicare item: 73371)* \$340.00   |
| Private patient in a recognised hospital  | ☐ EGFR amplification by FISH \$325.00  |
| Public patient in a recognised hospital   | THYROID CANCER   |
| Outpatient of a recognised hospital   | ☐ NGS thyroid DNA panel \$328.00   |
|   | ☐ NGS thyroid RNA fusion panel \$ 356.00   |
| INVOICING PROCEDURE   | GASTROINTESTINAL STROMAL TUMOUR (GIST)   |
| ☐ Bill Patient (Complete "Patient Authorisation Section" below)   | □ NGS GIST DNA panel \$328.00  |
| Bill Referring Department: Specify  | (NGS panel including KIT & PDGRFA)  BREAST and GASTRIC CANCER  |
| Bill Laboratory: Specify  | ☐ HER2 FISH (Medicare item: 73332)* \$315.40*  |
| Bulk Bill (Provide <b>Medicare Number</b> below)  | 22 GENE NGS DNA PANEL  |
| Important: Bulk billing applies only for the eligible tests marked with *.  | Gene list available on request \$ 328.00   |
| Specify billing party above for any non-Bulk billing tests if requested.  | 50 GENE NGS DNA PANEL  |
| 44 DIGIT MEDICARE NUMBER  | Gene list available on request \$398.00  |
| 11 DIGIT MEDICARE NUMBER  | I understand that if the cost of requested testing is not covered under Medicare,  |
|   | payment for tests performed is the responsibility of the requesting doctor or  |
| MEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973) PRACTITIONERS USE ONLY<br>TO BE COMPLETED BY PERSON ASSIGNMENT BENEFITS FOR THE SERVICES ON THE FORM | department, unless a signed patient consent to pay is provided.  |
| I offer to assign my right to benefits to the approved pathology practitioner who will render the requested   | REQUESTING DOCTOR'S SIGNATURE:   |
| pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the<br>practitioner.  | SAMPLE REQUIREMENTS (Send the following items in a <u>padded bag</u> ):  |
| Patient Signature: Date:  | <ul> <li>For NGS DNA panel: 10x unstained 5 μm sections on uncoated slides</li> </ul>  |
| Practitioner's use only (reason patient cannot sign):   | <ul> <li>For NGS RNA fusion panel: Paraffin block is required</li> <li>For IHC: 2x unstained 4 µm sections on coated slides</li> </ul> |
|   | <ul> <li>For FISH: 5x unstained 5 μm sections on coated slides</li> </ul>  |
| PATIENT AUTHORISATION   | <u>AND</u>   |
| I understand that my medical practitioner has requested a test that that is <b>not</b> covered by Medicare or not covered/partly covered by my private health fund.     | This test form completed in full   |
| I agree to accept responsibility for the full payment of the fees for this test:  | <ul> <li>A copy of the original pathology report</li> </ul>  |
| Cignatura   | ORIGINAL PATHOLOGY LAB:  |
| Signature: Date:  | BLOCK IDENTIFICATION NUMBER:   |
| Credit Card Number:   | ❖ SHIPPING ADDRESS:  |
|   | Molecular Laboratory, Anatomical Pathology Department  |
|   | Level 2, Main Building A, St Vincent's Hospital  |
| Expiry Date:       /     CCV:   | 41 Victoria Parade, Fitzroy VIC 3065   |
| Card Type: MasterCard VISA Amount: \$   | <ul> <li>CONTACT DETAILS:</li> <li>Phone: 03 9231 1049   Fax: 03 9231 4580   Email: Molecular@svha.org.au</li> </ul>                   |