



Molecular Oncology Test Request Form

Form: ANAT-MOL-F-201 v12

ACCREDITED LABORATORY NUMBER: 2531

PATIENT DETAILS (IN BLOCK LETTER)

Family Name:
Given Name:
Address:
Postcode:
DOB:
Gender:
Contact Phone No.:

REQUESTING PRACTITIONER (IN BLOCK LETTER)

Family name:
Given Name:
Address:
Postcode:
Provider No.:
Phone:
Fax:
Email (Required):

CLINICAL HISTORY

HOSPITAL STATUS OF PATIENT AT SPECIMEN COLLECTION OR DATE OF SERVICE

- Private patient in private hospital or approved day hospital facility
Private patient in a recognised hospital
Public patient in a recognised hospital
Outpatient of a recognised hospital

INVOICING PROCEDURE

- Bill Patient (Complete "Patient Authorisation Section" below)
Bill Referring Department: Specify
Bill Laboratory: Specify
Bulk Bill (Provide Medicare Number below)

Important: Bulk billing applies only for the eligible tests marked with *. Specify billing party above for any non-Bulk billing tests if requested.

11 DIGIT MEDICARE NUMBER

Grid for 11 digit Medicare number

MEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973) PRACTITIONERS USE ONLY TO BE COMPLETED BY PERSON ASSIGNMENT BENEFITS FOR THE SERVICES ON THE FORM

Patient Signature:
Date:
Practitioner's use only (reason patient cannot sign):

PATIENT AUTHORISATION

I understand that my medical practitioner has requested a test that is not covered by Medicare or not covered/partly covered by my private health fund. I agree to accept responsibility for the full payment of the fees for this test:

Signature:
Date:

Credit Card Number: Grid for card number

Expiry Date:
CCV:

Card Type: MasterCard VISA Amount: \$

TESTS REQUESTED

(Note: Bulk billing tests for eligible patients are marked with *)

Table listing tests requested: LUNG CANCER (NSCLC), COLORECTAL CANCER, MELANOMA, NEURO-ONCOLOGY, THYROID CANCER, GASTROINTESTINAL STROMAL TUMOUR (GIST), BREAST and GASTRIC CANCER, 22 GENE NGS DNA PANEL, 50 GENE NGS DNA PANEL. Includes test names, Medicare items, and prices.

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 department, unless a signed patient consent to pay is provided.

REQUESTING DOCTOR'S SIGNATURE:

SAMPLE REQUIREMENTS (Send the following items in a padded bag):

- For NGS DNA panel: 10x unstained 5 µm sections on uncoated slides
For NGS RNA fusion panel: Paraffin block is required
For IHC: 2x unstained 4 µm sections on coated slides
For FISH: 5x unstained 5 µm sections on coated slides

AND

- This test form completed in full
A copy of the original pathology report

ORIGINAL PATHOLOGY LAB:

BLOCK IDENTIFICATION NUMBER:

SHIPPING ADDRESS:

Molecular Laboratory, Anatomical Pathology Department
Level 2, Main Building A, St Vincent's Hospital
41 Victoria Parade, Fitzroy VIC 3065

CONTACT DETAILS:

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