TEST REQUEST FORM: Onco CGP

* Mandatory fields

PATIENT DETAILS

Forename* _____ **Surname*** _____

Hospital ID _____ **DOB (DD/MM/YYY)*** _____

Biological Sex* _____ **Patient ID** _____

HEALTH PRACTITIONER DETAILS

Account ID* _____ **Address 1*** _____

Full Name* _____ **Address 2** _____

Phone* _____ **City/town*** _____

Email* _____ **Post Code** _____

Institution* _____ **Country*** _____

TEST DETAILS

Tumour Tissue Comprehensive Genomic Profiling[1] | [1] Please refer to our webpage for information on the test targets.

CLINICAL INFORMATION

Diagnosis ☐ Breast ☐ NSCLC ☐ Ovarian ☐ Prostate ☐ Colorectal ☐ Melanoma ☐ Other: _____

Stage

Relevant results from other testing:

SAMPLE DETAILS

Sample requirements[2]**:**

- 10 air dried unstained sections mounted on slides at 5 micron (or 2mm^3).
- 1 representative H&E stained slide with area of highest neoplastic cell content clearly circled.

Specimen/Block ID*: | **Specimen (biopsy) site*:**

Approx % tumour cell content of H&E marked area*[3]:

[2]Please refer to our Laboratory User Guide for further information on the sample requirements for this test.

[3]Genetic analysis relies on sampling tumour tissue. Minimum of 20% tumour cell content required in the sample provided.

CONSENT

***Please, indicate how long you would like Genseq to store DNA sequencing raw data on your behalf:**

☐ **6 months** (default retention time where no option is chosen) ☐ **12 months**

In addition, in order to fulfil your instructions to perform the genetic testing undertaken in the context of an accredited genetic testing service, you understand that other data types, such as patient data received on this Test Request Form, laboratory QC data, secondary sequencing data and report data will be stored for a further period of years taking account of applicable law, regulation and industry guidance. In returning this Test Request Form for processing you are instructing us in writing to undertake such processing on your behalf.

☐ ***I hereby confirm that I have obtained written informed consent from the patient for this test to be performed, including consent for health practitioners registered under my account to access the report.**

BILLING AND REPORT DETAILS

The invoice for this test will be sent to the default billing address associated with your Account ID. If your institution requires a PO number, please insert it here: **PO Number** _____

☐ Patient Self Pay Patient phone number: _____ Patient email : _____

The report for this test will be made available in your account on Genseq's online ordering portal. If you need other health practitioners to have access to the report, please ensure they are registered under your account to ensure appropriate communication.

INTERNAL USE ONLY

Sample ID _____