pathlab

FORM 1 REQUEST FORM for Oncology Gene Testing

BRAF and EGFR gene mutation testing using Roche cobas CE-IVD accredited tests

PATIENT INFORMATION:

Surname:	**First Name:**	**NHI:**
Address:		
Date of Birth:	**Age:**	**Sex:**
Test Required:	**EGFR*** Lung EGFR incl ALK, IHC	**BRAF**

REQUESTING CLINICIAN / PATHOLOGIST:

Name: ______________________________

Laboratory: ___________________________

Address: ____________________________

____

Telephone: ___________ Fax: ___________

Mobile: _____________________________

Email: ______________________________

Signature:____________________________

COPY TO DOCTOR:

Name: ______________________________

Address: ____________________________

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Postcode: ___________________________

Fax:________________________________

Where appropriate organisation to be billed ________________________

CLINICAL INFORMATION:

____

***EGFR** FISH confirmation of POSITIVE **ALK** IHC results is recommended and will incur an additional cost

LABORATORY INFORMATION:

Originating Laboratory Name: ___________________Contact phone number: ________________

Block (slide) number(s)

Laboratory Request: ____________________Histology Accession number: _________________

Tissue in block/on slides (e.g. lymph node): _______________________________

If the test is not funded a completed Patient Form is required (Form 2)

Please ensure the following are dispatched in a padded bag:

- ☐ Completed Form 1
- ☐ Completed Form 2 (if non funded)
- ☐ Copy of Pathology Report
- ☐ Paraffin embedded block(s)

(Ensure blocks are labelled with laboratory number and patient name).

Courier or Post to:
Pathlab Bay of Plenty Ltd
Molecular Oncology Tests, Histology Department
829 Cameron Rd, Tauranga 3112
P.O. Box 130, Tauranga 3140

Enquiries: Dr Tim Sutton
molecular.testing@pathlab.co.nz
Phone: +64 7 578 7073
Website: www.pathlab.co.nz

IANZ ACCREDITED LABORATORY