PathWest LABORATORY MEDICINE WA
Hospital Avenue, Nedlands
Western Australia 6009
ABN 83 469 340 804

RESULTS & ENQUIRIES
13 PATH 7284

Molecular Anatomical Pathology
GENOMIC TEST REQUEST FORM
HRD

PathWest Lab I.D.

PATIENT Surname | Given Name (Including Middle Initial) | SEX ☐ M ☐ F ☐ Other | DOB: DD / MM / YYYY | UMRN

PATIENT Address | Telephone (Home) | Telephone (Business)

Is Patient of Aboriginal Descent? □ Yes □ No

Homologous Recombination Deficiency (HRD) testing *(validated assay, not yet NATA accredited)*

PLEASE TICK

☐ ***(please confirm):*** *for high grade serous or other high grade ovarian, fallopian tube or primary peritoneal carcinoma ONLY*

□ ***(please acknowledge)****: This assay may detect a variant of germline significance for both the patient and family members. Please ensure the patient is made aware of this.*

CLINICAL INFORMATION:

SPECIMEN DETAILS
(Please include PDF copy of external histopathology/cytopathology)
☐ Histopathology ☐ Cytopathology

Specimen Number

……

Laboratory

……

☐ PDF histopathology / cytopathology report included

Note for external pathology: *This testing requires the review of all H/E slides and use of relevant paraffin tissue blocks related to the case. The slides and blocks will be returned upon completion of testing. A small number of laboratories require payment for this request. In this instance, we will seek assistance from you, as the patient's treating oncologist, to gain access to the tissue.*

SEND THIS REQUEST FORM TO

QEmolecularap.Pathwest@health.wa.gov.au

BILLING

□ PUBLIC PATIENT

□ PRIVATE PATIENT

(**Note:** The cost of the HRD test is currently covered. When the test receives NATA accreditation, it will be eligible for the Medicare Benefit Scheme rebate)

REQUESTING CONSULTANT
Name: **Provider Number:**

Institution: **Fax** (*private consultants only*)**:**

X…… ……/……/…….
Requesting Doctor Signature

COPY DOCTOR(S):

Patient: I consent for my results to be stored in the iCM Signature: X……

LABORATORY USE