



Hospital Avenue, Nedlands  
Western Australia 6009  
ABN 83 469 340 804

RESULTS &  
ENQUIRIES  
**13**  
PATH  
7284

**Molecular Anatomical Pathology**  
**GENOMIC TEST REQUEST FORM**  
**COLORECTAL CANCER PANEL**

PathWest  
Lab I.D.

PATIENT Surname	Given Name (Including Middle Initial)	SEX M / F	DOB: DD / MM / YYYY	UMRN
PATIENT Address		Telephone (Home)		Telephone (Business)
Is Patient of Aboriginal Descent? <input type="checkbox"/> Yes <input type="checkbox"/> No				

**MBS Single Gene Detection:** **Medicare Item Number**  
*PLEASE TICK*  
 Metastatic colorectal cancer (Stage IV) 73338

KRAS exons 2, 3 and 4 and NRAS exons 2, 3, and 4 (somatic variant detection)

BRAF; Where no RAS variant is detected

**NON-MBS:**

Microsatellite Instability (MSI) test by Capillary Electrophoresis / Colorectal carcinoma

**CLINICAL NOTES**

<p><b>SPECIMEN DETAILS</b></p> <p><input type="checkbox"/> Histopathology <input type="checkbox"/> Cytopathology</p> <p>Specimen Number _____</p> <p>Laboratory _____</p>	<p><b>SEND THIS REQUEST FORM TO</b> <i>QEmolecularap.Pathwest@health.wa.gov.au</i></p> <p><b>BILLING</b></p> <p><input type="checkbox"/> MBS: MEDICARE DETAILS PROVIDED  <input type="checkbox"/> BILL TO PATIENT: COSTS DISCUSSED  <input type="checkbox"/> BILL TO INSURANCE PROVIDER:  <i>Insurer:</i> .....  <i>Policy Number:</i> .....</p>
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<p><b>Medicare Assignment</b>  <small>(Section 20A Health Insurance Act 1973)</small>          I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner.</p>	<p>PATIENT Signature and Date          X ..... /...../.....</p>	<p>MEDICARE NUMBER          ----- Ref _          Exp ___ / ___</p>
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<p><b>REQUESTING CONSULTANT</b></p> <p><b>Name:</b> _____ <b>Provider Number:</b> _____</p> <p>X..... /...../.....</p> <p>Requesting Doctor Signature  <i>I declare that this patient has been made aware of costs associated with the requested test.          Send results to HDWA Clinical Information System (iCM) – See CIS Informed Consent Information Sheet</i></p> <p>Patient: I consent for my results to be stored in the iCM      Signature: X.....</p>	<p><b>COPY DOCTOR:</b></p>
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**LABORATORY USE**