



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

RESULTS &
ENQUIRIES
13PATH
7284

Molecular Anatomical Pathology
GENOMIC TEST REQUEST FORM
SOLID TUMOUR - MBS

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 <i>PLEASE TICK</i>	Medicare Item Number
<input type="checkbox"/> Detection of neurotrophic receptor tyrosine kinase (NTRK1, NTRK2, NTRK3) fusions with diagnosis of: <ul style="list-style-type: none"> <input type="checkbox"/> Solid tumour (<18 years of age) <input type="checkbox"/> Mammary analogue secretory carcinoma of the salivary gland <input type="checkbox"/> Secretory breast carcinoma 	73433
<input type="checkbox"/> Detection of gene rearrangements by Next Generation Sequencing: <ul style="list-style-type: none"> <input type="checkbox"/> ALK <input type="checkbox"/> EWSR1 <input type="checkbox"/> NTRK1 <input type="checkbox"/> NTRK3 <input type="checkbox"/> PAX3 <input type="checkbox"/> PAX7 <input type="checkbox"/> PDGFRB 	73374
<input type="checkbox"/> Detection of Copy Number Variants (CNV) by Next Generation Sequencing: MDM2	73374

CLINICAL NOTES

SPECIMEN DETAILS <input type="checkbox"/> Histopathology <input type="checkbox"/> Cytopathology Specimen Number _____ Laboratory _____	SEND THIS REQUEST FORM TO QEmolecularap.Pathwest@health.wa.gov.au BILLING <input type="checkbox"/> MBS: MEDICARE DETAILS PROVIDED <input type="checkbox"/> BILL TO PATIENT: COSTS DISCUSSED <input type="checkbox"/> BILL TO INSURANCE PROVIDER: Insurer: Policy Number:
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Medicare Assignment (Section 20A Health Insurance Act 1973) 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.	PATIENT Signature and Date X /...../.....	MEDICARE NUMBER ----- Ref _ Exp /
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REQUESTING CONSULTANT Name: Provider Number: X /...../..... Requesting Doctor Signature <i>I declare that this patient has been made aware of costs associated with the requested test.</i> <i>Send results to HDWA Clinical Information System (iCM) – See CIS Informed Consent Information Sheet</i> Patient: I consent for my results to be stored in the iCM Signature: X.....	COPY DOCTOR: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
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LABORATORY USE