*Laboratory and Laboratory and* 

***NON-MBS Single Gene Detection***

*PLEASE TICK*

*Somatic variant detection of:*

□ TERT promoter hot spot mutation □ GNA11 hot spot variants □ PIK3CA hot spot variants

□ ERBB2 (HER2) hot spot variants □ MAP2K1 hot spot variants □ POLE hot spot variants

□ GNAQ hot spot variants □ MET hot spot variants, inc. exon 14 skipping □ TP53 loss of function variants

***NON-MBS Multi-Gene Next Generation Sequencing (NGS) Panels***

*□ AMPLISEQ: Analysis of 33 cancer related genes*

AKT1, ALK, APC, BAP1, BRAF, CDH1, CTNNB1, EGFR, ERBB2, FBXW7, FGFR2, FOXL2, GNAQ, GNAS, GNA11, IDH1, IDH2, KIT, KRAS, MAP2K1, MET, MSH6, MYD88, NRAS, PDGFRA, PIK3CA, POLE, PTEN, SMAD4, SRC, STK11, TERTp, TP53

*□ Trusight Tumour TST170*

Includes analysis of 170 cancer related genes for SNVs and indels, analysis of 59 genes for copy number variation and detection of gene rearrangement (fusions) and splicing events for 55 genes

*□ Trusight Oncology TSO500*

Analysis of 523 cancer related genes for SNVs and indels, analysis of 523 genes for copy number variation and 55 genes for detection of gene rearrangement (fusions) and splicing events. This assay also analyses Tumour Mutation Burden (TMB) and Microsatellite Instability (MSI).

In addition, Homologous Recombination Deficiency (HRD) testing can be requested for high grade serous ovarian cancer, please specify.

**CLINICAL NOTES**

**SEND THIS REQUEST FORM TO**

*QEmolecularap.Pathwest@health.wa.gov.au*

**BILLING**

□ PUBLIC PATIENT

□ PRIVATE PATIENT:

□ BILL TO PATIENT: COSTS DISCUSSED

**SPECIEMEN DETAILS** *(Please include PDF copy of external histopathology/cytopathology)* □ Histopathology □ Cytopathology

*Specimen Number*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Laboratory*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

□ PDF report included

**COPY DOCTOR:**

***REQUESTING CONSULTANT***

**Name: Provider Number: Fax** (*private consultants only*)**:**

X………………………………………………………………….. ……/……/……….

Requesting Doctor Signature

*(Private referrals only) 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*

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

***LABORATORY USE***

Molecular Anatomical Pathology

**GENOMIC TEST REQUEST FORM**

**SOLID TUMOUR – NON MBS**

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PathWest

Lab I.D.

Telephone (Business)

UMRN

□ Yes □ No

Telephone (Home)

DOB: DD / MM / YYYY

SEX M / F

Given Name (Including Middle Initial)

PATIENT Address

PATIENT Surname



Is Patient of Aboriginal Descent?