PATIENT LABEL

Clinical Information Form

Dear Treating Doctor,

The following clinical information is required for patients undergoing Genomic Profiling testing. Please complete the form below and return by email to QEmolecularAP.pathwest@health.wa.gov.au. Thank you.

Referral Document Checklist:

Completed molecular test request from

Completed clinical information form

Copy of histopathology report for sample which is to be tested

Patient Details				
Surname	**First Name**	**Date of Birth**	**Gender** M ☐ F ☐ Other ☐	**UMRN**
Address		**Phone**		**Medicare No.**

Pathology Provider Name:
For Pathology Provider Information Only: REQUEST FOR ACCESSION OF TISSUE This testing requires: • The review of all H/E slides • Use of relevant paraffin tissue blocks related to the case The slides and blocks will be returned upon completion of testing. Your assistance in providing this material would be greatly appreciated.

Referring Clinician	
Surname:	**First Name:**
Institution	
Email	
Provider Number	**Signature**

Patient Name/Label: _____

INCLUSION CRITERIA Patients must fulfil **all of the following** criteria to be eligible for this study	
Patient has: 1. pathologically confirmed advanced and/or metastatic solid cancer of any histologic type *or* 2. an earlier diagnosis of a poor prognosis cancer *or* 3. a diagnostic dilemma that has critical clinical management implications	☐ YES ☐ NO *Please indicate 1/2/3*
ECOG performance status, 0, 1 or 2	*Please indicate ECOG Status (0-5)*
Sufficient and accessible tissue for molecular screening? *Our experience has shown that there may be not enough tumour material in FNA for molecular screening.*	☐ YES ☐ NO *See notes below*

Notes:
Copy of histopathology report is required for enrolment to facilitate tissue collection for molecular screening. To gain access to your patient's tumour tissue, we will send a request to the pathology laboratory where your patient's tumour is located. 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. Histopathology report will be reviewed pre-consent to confirm adequacy for testing and if deemed unsuitable clinician will be contacted for alternatives or to confirm patient ineligibility.

DIAGNOSIS		
Date of Original Diagnosis	**Primary Site**	**Morphology**

STAGE

Current Stage: ☐ Locally advanced ☐ Distant Metastases ☐ Unresectable

Was the cancer metastatic, at the time of diagnosis? ☐ Yes ☐ No

If no, when was the diagnosis of metastatic disease made?

Past History of Cancer

Does the patient have a past history of cancer? ☐ YES (Please complete below) ☐ NO

Cancer Type: **Age at Diagnosis:** **Treating Institution:**

Previous Genetic Testing

Has the patient had previous genetic testing (germline or tumour), or have a known familial syndrome?
☐ No ☐ Yes (please provide details below):

Family History of Cancer (first and second degree relatives)		
Relation	**Cancer type**	**Age of Onset**

PathWest LABORATORY MEDICINE WA

Patient Name/Label: _____

NB. Month and year for all treatment dates below is sufficient if full date is not available

Surgery or Biopsy ☐ Yes ☐ No		
Date	Institution	Primary Procedure
Date	Institution	Primary Procedure
Date	Institution	Primary Procedure

Radiotherapy ☐ Yes ☐ No		
Start Date	Institution	Target Site(s)
Start Date	Institution	Target Site(s)
Start Date	Institution	Target Site(s)

Systemic Therapy ☐ No ☐ Yes (if yes, please include details in the table below) **Number of prior lines of systemic therapy including current:** _____				
Start Date	Institution	Drug(s)	Stop date	If ongoing, what cycle is the patient currently on?
Start Date	Institution	Drug(s)	Stop date	
Start Date	Institution	Drug(s)	Stop date	
Start Date	Institution	Drug(s)	Stop date	
Start Date	Institution	Drug(s)	Stop date	
Start Date	Institution	Drug(s)	Stop date	