NATA

PathWest LABORATORY MEDICINE WA

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RESULTS & ENQUIRIES
13 PATH 7284

Molecular Anatomical Pathology
GENOMIC TEST REQUEST FORM
TSO500 NGS

PathWest Lab I.D.

PATIENT Surname	Given Name (Including Middle Initial)	SEX	DOB: DD / MM / YYYY	UMRN
		☐ M	Telephone (Home)	Telephone (Business)
PATIENT Address		☐ F		
		☐ Other	Is Patient of Aboriginal Descent?	☐ Yes ☐ No

Non-MBS Comprehensive Genomic Profiling Panel:

TSO500 NGS

Comprehensive genomic profiling of solid tumours using Illumina NGS TSO500 gene panel. Includes analysis of 523 cancer related genes for SNVs and indels and copy number variants and 55 genes for detection of gene rearrangements (fusions) and splicing events. This assay also analyses Tumour Mutation Burden (TMB) and Microsatellite Instability (MSI).

PLEASE TICK

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

CLINICAL QUESTION (e.g. targetable genomic abnormality, trial eligibility, carcinoma of unknown primary, Lynch-like syndrome; ***please provide further details on pages 2 & 3***).

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 (REQUIRED)

☐ PUBLIC PATIENT

☐ PRIVATE PATIENT:
☐ BILL TO PATIENT: COSTS HAVE BEEN DISCUSSED

REQUESTING CONSULTANT

Name: **Provider Number:**

Institution: **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.

COPY DOCTOR(S):

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

LABORATORY USE

Clinical Information

Patient Name/Label: _____

INCLUSION CRITERIA Patients must fulfil **the following** criteria to be eligible for this test	
Patient has: 1. Pathologically confirmed advanced and/or metastatic solid cancer of any histologic type ***or*** 2. Pathologically confirmed early-stage poor prognosis cancer ***or*** 3. A diagnostic dilemma that has critical clinical management implications.	☐ YES ☐ NO *Please indicate 1, 2 or 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

PATHOLOGY		
Date of Original Diagnosis	**Specimen site**	**Diagnosis**

STAGE

Current Stage: ☐ Localised ☐ 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?

History of Cancer

Does the patient have a 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**

Clinical Information

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	