Sonic Genetics

Service available through Sonic Healthcare practices:

Douglass Hanly Moir Pathology
Sullivan Nicolaides Pathology
Melbourne Pathology
Barratt & Smith Pathology
Capital Pathology
Clinipath Pathology
Bunbury Pathology
Clinpath Pathology
Hobart Pathology
Launceston Pathology
North West Pathology
Southern.IML Pathology

INSTRUCTIONS FOR THE DOCTOR

Fax this form and a **copy of the histology and immunochemistry reports** to 1800 952 202 or email oncology@sonicgenetics.com.au.

All enquiries, please contact 1800 010 447.

Prosigna® | Request form

FOR THE MEDICAL SPECIALIST OR CONSULTANT PHYSICIAN FOR THE DOCTOR

This test should be requested by the specialist responsible for managing the patient's breast cancer treatment.

Patient details

First name _____

Surname _____

Date of birth ____/____/____ Sex Female

Address _____

_____

_____

Phone (mobile) _____

Test requested

☑ **Prosigna**

Please refer to the Sonic Genetics website, sonicgenetics.com.au/prosigna, for full details.

Clinical information REQUIRED

A copy of the histology and immunochemistry report is essential

Unless the laboratory is advised to the contrary, it is assumed that the patient has post-menopausal breast cancer that is ER+ and HER2 negative.

The following information is required to determine the risk score. Testing cannot proceed without this information:

Number of involved nodes: ☐ 0 ☐ 1–3 ☐ ≥4

Gross tumour size: ☐ ≤2 cm ☐ >2 cm

☐ Histology and immunochemistry report must be included.

Additional clinical notes _____

_____

_____

Holding laboratory and sample details

Sample must be breast tissue.

Holding laboratory details _____

Holding laboratory reference number _____

Sample block number _____

Patient name (as per block) _____

Date of birth (as per block) ____/____/____

Requesting doctor

Name _____

Address _____

_____

_____

Phone _____ Provider No. _____

I confirm that this patient has been informed about the purpose, scope and limitations of the test and that there is a private fee for testing, which needs to be prepaid.

DOCTOR SIGNATURE

X _____ Date

Copy reports to

Name _____

Address _____

_____

_____

FOR THE PATIENT – Patient, Privacy and Financial Consent

I confirm I have been informed about the purpose, scope and performance of the Prosigna test by my doctor, Prosigna patient literature, and/or the Sonic Genetics website. I understand that the test is performed from breast tissue collected previously, that the sample will be requested by Sonic Genetics from the holding laboratory for this test, and that the result should be reviewed by my doctor in the light of other findings. I have had the opportunity to ask questions and discuss these issues with my doctor, and understand that I can request further information. I consent to the Prosigna Test being performed and agree to prepay the fee for this test.

PATIENT SIGNATURE

X _____ Date

Full payment is required prior to sample retrieval and testing and Medicare benefits do not apply.

For pricing and term and conditions, please refer to our website – sonicgenetics.com.au/prosigna.

To finalise the order of your Prosigna test, your doctor will send your Prosigna request to Sonic Genetics. A representative will contact you to make full payment to complete your test request.

Sonic Genetics will begin the sample retrieval process with the holding laboratory on receipt of full payment of the test fee.

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SONIC HEALTHCARE

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