ONCOTYPE DX

CONSENT FORM

ADDRESOGRAPH

All fields must be completed LEGIBLY (patient demographics may be addressographed**).**

Patient Name(last, first) ________________________________, ________________________________

Date of Birth(d/m/y) ________/______/______ **Sex M** ☐ **F** ☐ **BC Cancer No.**______________________

Requesting MD/NP/RN ___________________ **MSC #**_______ **Phone** ________________________________

Fax ________________________________

Instructions to the submitting Physician / Nurse Practitioner / Nurse

Please submit this consent form using **Docusign**, or via fax with the attached fax cover page

to FAX № 604-708-2026

Compassionate Access Program phone number (1-800-663-3333 Ext 672675)

Patient Agreement for Tissue Acquisition and Testing

In order to provide you with the best treatment recommendation, your oncologist would like to obtain an Oncotype DX test on your cancer tissue. This test will not require any further surgery or biopsy.

The Oncotype DX test is done in the United States by Genomic Health, the company that owns the rights to this test. In order to perform the test, **some of your personal information will be received, processed and stored by Genomic Health in California, and its billing agent, also located in the US and therefore under all requirements of US Law.** This information is disclosed for the purposes of Oncotype DX diagnostic testing but may also be used to provide ongoing care and support, monitor the quality of care, to do research (with your consent or as the law permits), manage the payment/invoicing of this service and as required by law and authorised by the above act. Any questions regarding the collection of information can be directed to the office of the Provincial Lead for Systemic Therapy for BC Cancer at 250 519 5572. Subject to legal requirements, Genomic Health will not disclose your information to any third party for any reason or collect additional personal information about you without first obtaining your consent.

BC Cancer collects your personal information under the authority of section 26(c) of the British Columbia *Freedom of Information and Protection of Privacy Act.* This act prohibits the storage of your personal information outside of Canada without your explicit agreement. Personal information held by any company located in the United States of America (US) is potentially subject to disclosure demands from the US government authorities and, under US law, such demands may occur in secret.

To comply with the Freedom of Information act, BC Cancer requires your signature of agreement before ordering the Oncotype DX test.

I,____ instruct the laboratory storing my breast cancer tumour tissue to forward a tumour sample to Genomic Health for Oncotype DX testing. Although it is unlikely that this will use up all the stored tumour, I understand that if this does occur, further testing may not be possible on my cancer.

I understand that although Genomic Health does not intend to retain tumour tissue, tissue blocks or slides once the testing is complete, there is a possibility that these materials may be retained by Genomic Health. I agree that PHSA and BC Cancer are not responsible or hold any liability associated with the retention and handling of tissue, tissue blocks and slides by Genomic Health

I agree to provision of my personal information (name, date of birth, gender, Personal Healthcare Number, phone number and a copy of the pathology report) to Genomic Health to process this request. I understand that this information will be retained at the testing site with the test results for a minimum of 7 years. All the questions I have asked regarding the nature of the information that will be disclosed have been answered in a satisfactory manner and I agree to the release of the information to care providers who will be testing the sample/tissue.

The test results will be made available on a password protected website, hosted in the US. Clinical leaders will also have access to summary results through a website or in a paper report and they will use this information for quality assurance purposes only.

Patient Signature………………………………………………………… Date………………………………………

Physician / NP / RN Signature …………………………………………… Date………………………………………

Statement by professional interpreter, complete only if a professional interpreter is used to obtain agreement:
I have translated the above information to the: ☐ Patient/Client ☐ Parent ☐ Legal guardian or representative and I have interpreted their responses to the health care provider.

Signature of Interpreter	Print Name	Date

Oncotype DX Request

This fax transmission is for the use of Oncotype DX requests only and may contain information that is privileged and confidential.

Any dissemination, distribution or copying of this communication by unauthorized individuals is strictly prohibited.

If you have received this in error,

please contact the Compassionate Access Program phone number

(1-800-663-3333 Ext 672675), and then destroy this fax.

To: **(604) 708-2026**

Number of Pages _____ including this cover sheet.

From: ______________________________ Fax Number ________________________