Provincial Health Services Authority
Province-wide solutions. Better health.

BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority

Addressograph

ONCOTYPE DX
CONSENT AND TEST REQUEST

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

Patient Name(last, first) _____ _____

Date of Birth(d/m/y) _____**Sex M F BCCA No.**_____

Requesting Physician _____ **MSC #**_____**Phone** _____**FAX**_____

Originating Hospital:_____**Path. Specimen #:** _____

Instructions to the submitting Oncologist

Please submit this form and an Oncotype DX request form using the attached fax cover page

to FAX № 604-708-2026

Compassionate Access Program phone number (1-800-663-3333 Ext 672648)

Patient consent for tissue acquisition

The BC Cancer Agency 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 consent. 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.

The information we collect from you will be received, processed and stored by Genomic Health in California, (US) 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 Chief of Systemic Therapy at 1-866-663-3333 ext 6154. Vancouver Cancer centre, 600 West 10th Ave., Vancouver, BC, V5Z4E6. 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.

I,_____ instruct the laboratory holding my tissue block(s) to forward a representative tissue block or slides to Genomic Health for Oncotype DX testing. I consent to have core samples or sections removed from the block for testing. Although it is unlikely that the tumour in the block(s) would be exhausted, I understand that if this does occur, further testing may not be possible on the sample(s) submitted. I understand this test will not require any further surgery or biopsy.

I agree that although Genomic Health does not intend to retain 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 BCCA 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 consent 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.

Subject's Signature…… Date……

Witness' Signature…… Date……

Signature of Physician…….. Date……

Statement by professional interpreter, complete only if a professional interpreter is used to obtain consent.
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

Provincial Health Services Authority
Province-wide solutions. Better health.

BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority

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 672648), and then destroy this fax.

To:- **604-708-2026**

Number of Pages _____ including this cover sheet.

From:- _____ Fax Number _____