

SECTION I. SUBMISSION STATUS
 FIRST SUBMISSION RESUBMISSION — Original Requisition No. _____ STUDY NAME / CODE _____

SECTION II. ASSAY & SPECIMEN CRITERIA

Oncotype DX Breast Cancer Assay

Ductal Carcinoma In Situ — OR — Invasive Breast Cancer

DCIS Score™ for Ductal Carcinoma In Situ Patient (no invasive cancer present)

Recurrence Score® for Invasive Breast Cancer Patient

ER STATUS: Positive Negative Inconclusive by IHC Unknown

*NODE STATUS: Negative Positive 1-3 Positive 4+

Micromets pN1mi (0.2-2.0mm)

Oncotype DX Colon Cancer Assay

Important: Stage (AJCC 6th ed.) and Assay selection determines the results presented on the report.

Stage II Patient (T3 or T4) AND Node Negative

Sequential Assays: MMR then Oncotype DX Colon Cancer if MMR Proficient

Oncotype DX Colon Cancer Assay (for known MMR Proficient tumors)

Stage III A/B Patient Any T AND 1-3 Positive Nodes

Oncotype DX Colon Cancer and MMR Assays

Oncotype DX Colon Cancer Assay

SECTION III. ORDERING PHYSICIAN

LAST NAME: Smith
 FIRST NAME: John
 PHONE: 555-555-1234 FAX: 555-555-4321
 E-MAIL: _____
 INSTITUTION / DEPARTMENT: ABC Hospital
 STREET ADDRESS: 123 Hospital Dr.
 CITY: Anytown PROVINCE: BC
 POST CODE: _____ COUNTRY: _____
 OFFICE CONTACT NAME & E-MAIL: _____

ADDITIONAL PHYSICIAN (Optional)

LAST NAME: _____
 FIRST NAME: _____
 PHONE: _____ FAX: _____
 E-MAIL: _____
 INSTITUTION / DEPARTMENT: _____
 STREET ADDRESS: _____
 CITY: _____ PROVINCE: _____
 POST CODE: _____ COUNTRY: _____
 OFFICE CONTACT NAME & E-MAIL: _____

PATHOLOGY (Optional)

LAST NAME: _____
 FIRST NAME: _____
 PHONE: _____ FAX: _____
 E-MAIL: _____
 INSTITUTION / DEPARTMENT: _____
 STREET ADDRESS: _____
 CITY: _____ PROVINCE: _____
 POST CODE: _____ COUNTRY: _____
 OFFICE CONTACT NAME & E-MAIL: _____

SAMPLE

SECTION IV. PATIENT

LAST NAME: Doe FIRST NAME: Jane
 DATE OF BIRTH (Day / Month / Year): 01/01/1965 Female Male
 MEDICAL NUMBER: _____
 STREET ADDRESS: _____
 CITY: _____ PROVINCE: _____
 POST CODE: _____ COUNTRY: _____
 PHONE: _____ E-MAIL: _____

SECTION V. BILLING — Please select ONE billing or payment option and complete the information. (See reverse for details.)

SUBMITTING DIAGNOSIS: Breast Cancer ICD-10 CODE: _____

Select one billing option: 1) INSURANCE 2) INSTITUTION / HOSPITAL (Restricted to contracts on file with GHI.) 3) PATIENT

Please complete below for bill insurance or institution option & attach copy of insurance card.

INSURANCE or INSTITUTION: Bc Cancer Agency

PATIENT INSURANCE NUMBER: _____ INSURANCE AUTHORIZATION NUMBER: _____
 STREET ADDRESS: _____ CITY/PROVINCE: _____ POST CODE: _____
 COUNTRY: _____ PHONE: _____

SECTION VI. SPECIMEN INFORMATION (REQUIRED)

SPECIMEN RETRIEVAL

Genomic Health to request specimen on my behalf.

LOCATION OF SPECIMEN: XYZ Labs

PHONE: 555-123-4567 FAX: 555-321-7649

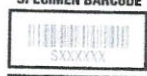

Ordering Physician to request specimen.

MULTIPLE PRIMARIES Is more than one primary tumor being submitted for testing? YES NO
 Specimens will be processed as listed below.

SPECIMEN / CASE NUMBER: Only one specimen is typically required

1. SP-121222-A

2. _____

SPECIMEN BARCODE:  

DATE OF SURGERY (Day / Month / Year): 29/04/2014

SECTION VII. PHYSICIAN SIGNATURE & SPECIMEN STATUS

PHYSICIAN SIGNATURE (Required): John Smith DATE (Day / Month / Year): 01/05/2014

NAME: _____

Your signature confirms that you have read and accept the terms stated on the reverse side. Specifically by signing this form you are stating that either 1) the patient meets the criteria stated on the reverse side of this form OR 2) if the patient does not meet these criteria, that you have selected the exceptions as they apply or indicated them in the Exception Criteria space below. GHI may contact you should your patient not meet these criteria.

EXCEPTION CRITERIA (See reverse for definition): _____

BLOCK RETURN LOCATION (Leave blank if submitting slides.) STREET ADDRESS CONTACT NAME PHONE