Genomic Health | oncotype DX

Customer Service Contact Information

	Phone	Fax
Canada	(866) ONCOTYPE (866) 662 6897	1 650 569 2081
Other	+1 650 569 2080	+1 650 569 2081

Oncotype DX® Requisition Form

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
- ☐ Micromets pN1mi (0.2-2.0mm)
- ☐ Positive 1-3
- ☐ Positive 4+

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:

SAMPLE

PATHOLOGY (Optional)

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

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

	SPECIMEN BARCODE	DATE OF SURGERY (Day / Month / Year)
1. SP-121122-A	SXXXXX	29/04/2014
2.	SXXXXX	

SECTION VII. PHYSICIAN SIGNATURE & SPECIMEN STATUS

PHYSICIAN SIGNATURE (Required): X 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 definitions.)

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

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