Sonic Genetics
Sullivan Nicolaides Pathology

prosigna®
Breast cancer
prognostic gene signature assay

Prosigna® | Request Form

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) _____

Clinical information REQUIRED

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. Please include a copy of the histology and immunochemistry reports with this request form.

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

If these details are left blank, Sonic Genetics will assume that the laboratory providing the histology report is also holding the sample required for this test. **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 _____

By signing this form I confirm that I have the consent of the patient to request Prosigna breast cancer gene signature assay, and that the patient is aware they will need to prepay for this test.

Signature ✖ DOCTOR SIGNATURE Date

Copy reports to

Name _____

Address _____

FOR THE PATIENT – Patient 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 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.

Signature ✖ PATIENT SIGNATURE Date

Sample collection appointment and payment

Prosigna is a specialist service and **this test must be pre-booked.**

Full payment is required prior to sample collection and **Medicare benefits** do not apply.

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

To finalise the order of your Prosigna test, please contact us on 1800 010 447 to complete your booking. You will need to have this form at hand.

To finalise the request for your patient, please fax this complete request form to 1800 515 119. You can also email this request to info@sonicgenetics.com.au. Sonic Genetics will begin the sample retrieval process with the holding laboratory on receipt of full payment of the test fee. Medicare benefits do not apply.

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