

Patient Information

Surname _____
Given Name(s) _____
MRN _____ D.O.B. ____/____/____ Sex _____
Patient Address _____
Post code _____
Telephone _____
Medicare No. _____
Private Health Fund _____
☐ Do Not Send Report to My Health Record

Hospital status of patient at specimen collection or date of service

Private patient in a private hospital or approved day hospital facility ☐ Yes ☐ No
Private patient in a recognised hospital ☐ Yes ☐ No
Public patient in a recognised hospital ☐ Yes ☐ No
Outpatients of a recognised hospital ☐ Yes ☐ No

Clinic status

☐ Public ☐ MBS

Tests Requested

Select Anatomical Pathology/Other test(s) if appropriate

☐ Histology ☐ Cytology ☐ Other

Note: If ordering at the time of biopsy/resection (prior to a confirmed histological/cytology diagnosis) please also select from the following options. If a relevant cancer is detected at >10% tumour purity the laboratory will proceed with the molecular testing requested.

NGS Panels

☐ Colorectal* (73338) ☐ Gastrointestinal Stromal Tumour**
☐ Melanoma* (73336) ☐ Endometrial Carcinoma**
☐ NSCLC (☐ tick to include TP53)* ☐ Ovarian Granulosa Cell Tumour* (73377)
☐ New Diagnosis (73438)
☐ EGFR gene status (73337)
☐ Stage IIIB or IV (73351)
☐ Locally advanced (METexon 14 skipping) (73436)
☐ Tumour not otherwise specified above - Full NGS panel **

☐ Single Gene or other specific genes on NGS panel** (_____)

Other

☐ NSCLC EGFR Idylla Test* (73337) ☐ BRAF Idylla Test* (73336)
☐ MLH1 Promoter Methylation Analysis**

*Medicare rebates available, subject to criteria being met. **Non-MBS Rebutable
Refer to the Austin Pathology website for more information and gene lists: www.austinpathology.org.au/molecular-genetics

Request Submission

Provide the following:

- Completed form
- Appropriate sample*
- Copy of the histology or cytology test report

*Please check sample requirements in Austin Pathology's Test Directory.

<https://www.austinpathology.org.au/test-directory>

Clinical Notes

☐ SD

Sample Details

Lab Number of Sample _____ Urgent ☐ Yes ☐ No
☐ Resection ☐ Biopsy ☐ Cell Block
☐ Other _____
Specify clinical reason for urgency _____

Referring Doctor

Name _____
Address _____
Phone _____ Fax _____
Email _____
Provider No. _____

DOCTOR'S SIGNATURE AND REQUEST DATE

X _____/_____/_____

Copy Report To

Name _____
Address _____
Provider No. _____

Patient and Financial Consent

Medicare Assignment (Section 20A of the HIA 1973):

I offer to assign my right to benefits to the approved practitioner who will render the requested pathology service(s) and any eligible pathological determinable service(s) established necessary by the practitioner.

Financial Acknowledgment:

The pathology request that you have been given by your medical practitioner may include tests that could be either partially or not covered by Medicare. If required, the full cost of testing must be covered by the patient or, in the case of children, their family. Austin Pathology requires your consent to proceed with this testing with the full understanding that you will accept responsibility for payment.

PATIENT SIGNATURE AND DATE

X _____/_____/_____

PRACTITIONER'S USE ONLY (Reason for patient being unable to sign)

For further information on pricing, please contact Austin Pathology's Molecular department on 03 9496 5657.

Please forward request form and specimen to:

Austin Pathology - Anatomical Pathology
Fax (AP): 03 9496 3437 or Email: molecular@austin.org.au
Address: Austin Health; HSB Level 6, 145 Studley Road,
Heidelberg VIC 3084