

Patient Details					Molecular Oncology Test Requested (* Medicare item)									
Family Name					Molecular Oncology Test		Medicare Item	Non-Medicare Item						
Given Name					Lung Cancer									
Address					<input type="checkbox"/> Next Generation Sequencing (NGS)									
		Postcode			<input type="checkbox"/> NGS Lung Cancer Panel (no fusions)		73438*							
D.O.B		Gender	<input type="checkbox"/> F	<input type="checkbox"/> M	<input type="checkbox"/> Unknown	<input type="checkbox"/> NGS EGFR T790M Test		73351*	73439*					
UR No.					<input type="checkbox"/> NGS Lung RNA Fusion Panel (select this for MET exon 14 skipping, gene fusions including NTRK1-3)									
Phone/Mobile No.					Immunohistochemistry (IHC)									
					<input type="checkbox"/> IHC ALK <input type="checkbox"/> reflex FISH if positive		72846*							
					<input type="checkbox"/> IHC ROS1 <input type="checkbox"/> reflex FISH if positive		72846*							
					<input type="checkbox"/> IHC PD-L1		72814*							
Requesting Practitioner					Fluorescence In Situ Hybridisation (FISH)									
Family Name					<input type="checkbox"/> FISH ALK		73341*							
Given Name					<input type="checkbox"/> FISH ROS1		73344*							
Address					<input type="checkbox"/> FISH RET		N/A	\$ 400						
		Postcode			Colorectal Cancer									
Provider No.		Phone No.			<input type="checkbox"/> NGS Colorectal Cancer Panel		73338*							
Send Report		Email			<input type="checkbox"/> MLH1 Promoter Methylation		N/A	\$ 220						
		Fax			Melanoma									
Copy Report		Name			<input type="checkbox"/> NGS Melanoma Panel		73336*							
		Email			Neuro-Oncology									
		Fax			<input type="checkbox"/> NGS IDH1/IDH2 Panel		73372*							
						<input type="checkbox"/> FISH 1p/19q Deletion		73371*						
						<input type="checkbox"/> FISH EGFR Amplification		N/A	\$ 300					
						<input type="checkbox"/> MGMT Promoter Methylation		73373*	\$ 300					
Clinical History					Thyroid Cancer									
					<input type="checkbox"/> NGS Thyroid DNA Panel		N/A	\$ 400						
					<input type="checkbox"/> NGS Thyroid RNA Fusion Panel		N/A	\$ 465						
Hospital Status of Patient at Specimen Collection or Date of Service					NTRK fusion by NGS									
<input type="checkbox"/> Private patient in private hospital or approved day hospital facility <input type="checkbox"/> Private patient in a recognised hospital <input type="checkbox"/> Public patient in a recognised hospital <input type="checkbox"/> Outpatient in a recognised hospital					<input type="checkbox"/> For mammary analogue secretory carcinoma of salivary gland, secretory breast carcinoma or pediatric tumours		73433*							
					<input type="checkbox"/> For other indications		N/A	\$ 465						
					Breast and Gastric Cancer					<input type="checkbox"/> FISH HER2 Amplification		73332*		
					Other NGS Panel Available					<input type="checkbox"/> NGS OPA DNA Panel		N/A	\$ 400	
Invoicing Procedure					<input type="checkbox"/> NGS OPA RNA Fusion Panel		N/A	\$ 465						
Medicare Criteria Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Bulk Bill – Provide Medicare Number Below (Required #) <input type="checkbox"/> Bill Referring Department (Specify:) <input type="checkbox"/> Bill Laboratory (Specify:) <input type="checkbox"/> Bill Patient - Complete Patient Authorisation Section Below (Required #)					Requesting Doctor Declaration									
					I understand that if the cost of requested testing is not covered under Medicare, payment for tests performed is the responsibility of the requesting doctor or department, unless a signed patient consent to pay by credit card is provided.									
Medicare Number + Reference Number					Signature									
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> ← Ref #		(Electronic signature accepted)		<input type="text"/>		<input type="text"/>						
<small>MEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973) PRACTITIONERS USE ONLY TO BE COMPLETED BY PERSON ASSIGNMENT BENEFITS FOR THE SERVICES ON THE FORM I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner.</small>					Shipping Address									
Patient Signature (Electronic signature accepted)				Date		Attention: Molecular Laboratory Anatomical Pathology Department, Level 2, Main Building A, St Vincent's Hospital, 41 Victoria Parade, Fitzroy VIC 3065								
Reason for not signing (Practitioner's Use Only)					Sample Requirements (Send the following items in a padded bag):									
Patient Authorisation					<ul style="list-style-type: none"> • NGS DNA panel: 1 H&E + 10x 5 µm tumour tissue sections • NGS RNA fusion panel: 1 H&E + Paraffin block • IHC: 2x 4 µm tumour tissue sections on coated slides • FISH: 5x 5 µm tumour tissue sections on coated slides • MGMT Methylation: 1 H&E + 10x 5 µm tumour tissue sections • MLH1 Methylation: 1 H&E + 10x 5 µm tumour AND normal tissue sections • Completed Molecular Oncology Test Request Form (Required) • A Copy of the Original Pathology Report (Required) 									
Patient Signature (Electronic signature accepted)				Date		Original Pathology Lab								
Credit Card Number					Block ID Number									
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/>								
Expiry Date:				CCV:		<input type="text"/>								
Card Type:		<input type="checkbox"/> Visa	<input type="checkbox"/> Mastercard	<input type="text"/>										
Amount:		A\$			<input type="text"/>									