

KRAS, BRAF and EGFR Test Request Form

***Tests Required (please tick) KRAS KRAS & BRAF BRAF EGFR**

Instructions for Requesting Physicians:

1. Please fill out sections A, B and C of this form and indicate which test(s) you require (tick box above)
2. Please fill out the Lab21 Payment Form on the back of the Test Request Form
3. Fax or email the completed forms to Lab21 Ltd on +44 (0)1223 395451 or info@lab21.com
4. Then Fax/email the completed Test Request Form to the Sample Retention Site –identified in section C

Section A – Patient Information

Please note the fields marked * are compulsory

Please fill out completely or affix sticker here.

You must include at least 3 unique patient identifiers*

*Patient's First Name..... *Patient's Last Name.....

*Date of Birth(DD/MM/YYYY) Date Tumour Taken(DD/MM/YYYY)

NHS No Hospital ID No Pathology Report No.

*Cancer diagnosis:

*What line of therapy is planned for this patient: None Chemo Only Adjuvant 1st Line 2nd Line 3rd Line

*Select one only: NHS Patient Private Insurance Patient Self-Funded Patient

*Is testing funded by a pharmaceutical company? No Yes, as shown below:

Company: Test(s):

Company: Test(s):

*Has the patient had previous chemotherapy treatment for non small cell lung cancer: Yes No

Section B – Requesting Physician Information

Hospital Ref. No. *Physician Name

*Clinic/Hospital.....

Address

Postcode Tel Fax *Email

*Preferred method for reporting results: Email Post Fax

I hereby authorise a tumour sample of the above mentioned patient to be tested for mutations in the KRAS, BRAF and/or EGFR genes (as selected) by Lab21 Ltd, Cambridge, UK.

*Physician Signature *Date

The provision of services by Lab21 Ltd is subject to our Standard Terms and Conditions, a copy of which can be obtained from our Customer Services Dept. Each submission of a Test Request Form for services by a Client to Lab21 Ltd will be deemed to be an acceptance by the client to purchase the required service subject to the aforementioned Terms and Conditions.

Section C – Pathology Laboratory/Sample Retention Centre Information

Contact Name *Centre Name

Address

Postcode Tel..... Fax Email

*Pathologist Signature *Date

Please indicate whether you require the biopsy sample returned or destroyed (please tick one)

For the Pathologist:

1. The physician named above has faxed you this form to seek your assistance in providing a tissue sample for important clinical testing.
2. You will receive a Sample Preparation Kit, including clear instruction for preparation and shipment of a suitable tumour sample, at your site in the next few days.
3. When you receive the Sample Preparation Kit, please:
 - Prepare a tumor sample according to the instructions provided, then **complete the identifier labels with at least 3 unique identifiers (i.e. first name, last name and date of birth) and attach to the primary sample containers i.e. the sample tubes.**
 - Sign the copy of the Physician's completed Test Request Form (that will be included with the Sample Collection Kit) to confirm that you have prepared a sample from the patient identified.
 - Finally return the signed form with the tumour sample to Lab21 Ltd in the Freepost envelope provide.

If you have any questions about why this test has been requested-please contact the requesting physician. If you have any questions about sample preparation or the test itself –please contact Lab21 Ltd on +44 (0)1223 305450. PLEASE NOTE: Lab21 Ltd **do not require** any histopathology report or documentation associated with the tumour sample.

Lab21 USE ONLY ID No Date..... Entered by..... Validated by.....

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