

## CancerTYPE ID® Test Request Form

### Instructions for Requesting Physicians:

1. Please complete the form as carefully as you can, with the exception of information to be filled in by the Pathologist. **Any missing information on the form may lead to delay in performing the analysis. Missing compulsory information may result in test cancellation.**
2. Fax or email the completed forms to Lab21 on +44 (0)1223 395451 or Email [cupcheck@lab21.com](mailto:cupcheck@lab21.com).
3. Finally, fax/email the completed Test Request Form to the Pathology Laboratory.

### A. PATIENT AND SAMPLE 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/YY) .....

Patient Gender (M/F) ..... Patient ID No. .... Hospital No. .... \*Pathology Report No. ....

\*Date of Biopsy ..... \*Site of Biopsy .....

\*Biopsy Collection Procedure  Resection  Other .....

\*Fixative  10% Neutral Buffered Formalin  Other .....

Please note that only paraffin embedded tissue biopsies fixed in formalin or Bouin's solution can be used for testing.  
Please note that bone biopsy samples should be decalcified using formic acid. Tissue decalcified using hydrochloric acid cannot be used for testing.

\*Clinical diagnosis: .....

### B. REQUESTING PHYSICIAN INFORMATION

Hospital Ref. No..... \*Physician Name .....

\*Clinic/Hospital ..... \*Address .....

..... Postcode .....

\*Tel ..... Fax ..... Email.....

\*Preferred method for reporting results:  Email  Post  Fax

\*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 Lab21 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.

### C. PATHOLOGY LABORATORY INFORMATION

Contact Name ..... \*Centre Name .....

Address .....

Postcode ..... \*Tel: ..... Fax: ..... Email .....

\*Pathologist Signature ..... \*Date .....

**LAB21 Use Only** ID No ..... Date ..... Entered By ..... Validated By .....

### For the Pathologist:

1. The physician named above has faxed you this form to seek your assistance in providing a tissue sample for an important clinical test.
2. You will receive a CancerTYPE ID® Sample Collection Kit, including clear instructions for preparation and shipment of a suitable tissue block, at your site in the next few days.
3. When you receive the Sample Collection Kit, please:
  - Prepare the samples according to the instructions provided, **including identifier labels with at least 3 unique identifiers (i.e. first name, last name and date of birth) attached to the primary samples (i.e. blocks or slides)**
  - Fill in the remaining sample related information and sign the copy of the Physician's completed CancerTYPE ID® Test Request Form to confirm that you have prepared a sample from the patient identified.
  - Take a copy of the Pathology Report associated with the sample.
  - Finally return the signed form with the tumour sample **and the Pathology Report** to Lab21 Ltd in the Freepost envelope provided.

If you have any questions about why the CancerTYPE ID® test has been requested, please contact the requesting physician. If you have any queries about sample preparation itself, please contact Lab21 Ltd on 0845 6778109.

Lab21 Ltd, 184 Cambridge Science Park, Cambridge CB4 0GA, UK  
T: 0845 6778109 (UK), +44 (0)1223 395450 (International)  
F: +44 (0)1223 395451 E: [cupcheck@lab21.com](mailto:cupcheck@lab21.com)

## CancerTYPE ID® Test Request Form Payment Form

Please note: If Lab21 does not receive full payment information your testing may be delayed

### Patient Information

Patient Name

Date of Birth (NB please use the following format e.g. 02 JAN 2005)

(Day)
 
 (Month)
 

 (Year)

### Payment by Credit Card



Card Type  MasterCard  Maestro  Visa  Visa Electron  American Express\*

\* Please note that payments by American Express will have a 3% handling fee applied

Card Number

Expiry 
 (MM/YY) Security code 
 (on reverse of card)

Post Code  House Number

### Insurance details

Name of insurance party/ reimbursement party

Invoice address

Insurance claim number

Customer reference number

### Payment by Bank Transfer

Lloyds TSB Bank Plc  
39 Threadneedle Street  
London EC2R 8AU UK

Sort Code: 30-00-09  
Account Number: 0300 6896

### Payment by cheque

Cheques should be made payable to "Lab21 Ltd"

**Lab21 Ltd**, 184 Cambridge Science Park, Cambridge CB4 0GA, UK  
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