StageCheck

Previstage™ GCC Colorectal Cancer Staging Test Request Form

Instructions for the 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 stagecheck@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's Address.....

*Post Code..... Patient Gender (M/F) ..... Patient ID No. ..... Hospital No. .....

*Date of Surgery ..... *Specimen Source ..... Pathology Report No. .....

Surgical Procedure ☐ Resection ☐ Other..... *Fixative ☐ 10% Neutral Buffered Formalin ☐ Other.....

*Are you submitting more than 15 lymph node sample blocks for this patient? ☐ Yes ☐ No

*Block ID	*No. of whole lymph nodes in the block	*No. of bisected lymph nodes in the block	Corresponding slide ID (if applicable)

NOTE: Typically, half of each whole lymph node or the entire post-surgically bisected lymph node is used for analysis, and the remaining tissue is re-embedded and returned to the Pathology Laboratory. However, if submitted lymph nodes measure 2mm or less, they will be used in their entirety. Also, lymph node samples bisected post-embedding will be used in their entirety. If these lymph node samples should be returned untested, please sign and date here.

Signature..... Date .....

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 ..... *Laboratory 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 Sample Collection Kit, including clear instructions for preparation and shipment of a suitable lymph node samples, 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 Test Request Form to confirm that you have prepared a sample from the identified patient.
   - Finally return the signed form with the lymph node sample blocks, and preferably with a copy of the histopathology report, to Lab21 Ltd in the Freepost envelope provided.

If you have any questions about why this test has been requested, please contact the requesting physician. If you have any queries about sample preparation itself, please contact Lab21 Ltd on 0845 6778108 (UK), or +44 (0)1223 395450 (International).

Previstage™ GCC was developed and is performed exclusively by DiagnoCure Oncology Laboratories of West Chester, Pennsylvania. Previstage™ GCC is a trademark of DiagnoCure Inc.

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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"