Second generation breast cancer prognostic test

EndoPredict®

myriad WHEN DECISIONS MATTER

Laboratory: Myriad GmbH
Bunsenstrasse 7
82152 Martinsried - Germany
customersupport@myriadgenetics.eu

Myriad Genetics GmbH
Leutschenbachstrasse 95
8050 Zurich - Switzerland
www.myriadgenetics.eu

Affix one bar code label here

TEST REQUEST FORM

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

Please print all information in BLOCK LETTERS

PATIENT

DATE OF BIRTH (DD-MMM-YYYY):

GENDER: FEMALE | PATIENT ID:

LAST NAME:

FIRST NAME:

BILLING INFORMATION

PAYOR ID:_____

or

RESEARCH #:_____

or

VOUCHER #:_____

ORDERING PHYSICIAN

LAST NAME: | DEGREE: Dr.

FIRST NAME: | CLINICAL ID:

INSTITUTION:

STREET, NR:

CITY, POSTAL CODE:

COUNTRY: | DAY PHONE:

☐ Send results electronically and by mail | FAX:

E-MAIL:

INTERNAL USE ONLY: Results to Myriad GmbH, # 116309

AUTHORIZED SIGNATURE (Physician/Healthcare Provider)

I hereby authorize testing and confirm that informed consent has been obtained from the patient for tissue to be sent to Myriad for analysis. I confirm that this test is medically necessary and results will be used in the medical management and treatment decisions for the patient. I hereby attest that the person listed in the Ordering Physician space above is authorized by law in the relevant jurisdiction to order the test requested herein.

_____ Ordering Physician / Healthcare Provider's Signature

Date (DD-MMM-YYYY)

PATIENT AUTHORIZATION (required only for release of results to a third party)

In addition to my consulting physician(s), I authorize the results of my testing be released, if requested, to:

Name | E-mail | Patient's signature | Date (DD-MMM-YYYY)

Forward This Test Request Form To The Laboratory Where The Tumor Specimen Is Located.

CLINICAL/PATHOLOGICAL INFORMATION TO DETERMINE THE EPCLIN SCORE. Please provide the following parameters:

Breast Cancer: Age at Dx:_____

Date of biopsy/surgery (DD-MMM-YYYY):

Tumor Size: ☐T1a ☐T1b ☐T1c ☐T2 ☐T3 (only invasive area)

ER: ☐ negative ☐ positive

HER2 Status: ☐ negative ☐ positive

Lymph node status (number of positive lymph nodes): ☐ 0 ☐ 1-3 ☐ 4-10 ☐ >10

SPECIMEN INFORMATION: TO BE COMPLETED BY PATHOLOGIST. (Complete instructions are in the Instructions For Use (IFU) sheet). For a specimen collection set please contact testkit@myriadgenetics.eu

Paraffin Block with at least 30% of Tumor Tissue:

Specimen Type: ☐ Slides ☐ Blocks Tissue/Tumor Type: ☐ Post Surgical ☐ Biopsy Sample Fixative: ☐ 10% neutral buffered formalin ☐ Other : _____

☐ Tissue Block enclosed | Number of Blocks _____ | ID*_____ | ☐ H&E slide (2-5 microns thickness)

☐ Tissue Slides enclosed (10 microns thickness) | Number of Slides _____ (minimun of 5 slides) | ID*_____ | ☐ H&E slide (2-5 microns thickness)

PLEASE NOTE: A COPY OF THE PATHOLOGY REPORT MUST BE SUBMITTED WITH SPECIMEN

*Specimen Identification Number as it appears on the tissue blocks or slides submitted to Myriad.

AUTHORIZED SIGNATURE (Pathologist or authorized representative)

I hereby declare that the clinical information described above on this Test Request Form is correct and the tissue belongs to the patient mentioned above.

_____ Pathologist or Authorized Representative Name (in PRINTED LETTERS)

_____ Signature | Date (DD-MMM-YYYY)

TISSUE RETURN

I request the remaining tissue to be returned. ☐ Yes ☐ No

Name: _____

Address: _____

_____

E-mail / Phone: _____

INTERNAL USE ONLY: Bill Institution BIE _____.

For information or questions regarding Myriad's Safe Harbor privacy policy, please visit our website: http://www.myriadgenetics.eu

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