

Grafton Clinical Genomics

Prosigna Test Request Form

Requesting Clinician to Complete:	
Requesting Doctor:	Patient Information:
Name: _____	NHI # _____
Address: _____	Date of Birth: _____
_____	Name: _____
Contact no. _____	Sample ID _____
Email for Report:	Sample date: _____
CC to: _____	Menopausal Status: _____
_____	(Please Note: Prosigna has been validated for use in Post-menopausal women. Recent publications show Prosigna's intrinsic subtype is independent of menopausal status and provides prognostic information in both Pre and Post menopausal women.)
Please note: Prosigna report will be sent to email address provided above	

Patient to Complete:	
Payment Details (Samples will not be processed unless payment has been confirmed): Cost of Testing is \$3600(GST included)	Patient's consent: I understand that laboratory testing on my tissue is part of a clinical workup for my condition and the testing to be undertaken has been explained to me by the requesting clinician. I give permission for my tissue to be used for the Prosigna laboratory test(s)
Internet Banking Details (Please use 651/2905 as 'reference' and SURNAME and DOB of patient as 'particulars'):	
Please provide an email address below for invoice to be sent to. Payment details will be provided with invoice.	
Email for Invoice:	Patient's signature, Date

Pathologist to Complete:						
Please, provide the following information:						
Sample requirement for Prosigna test:			Criteria Met?			
			Yes	No		
1	The patient has breast cancer that is ER+ and HER2 negative					
2	The tumor cellularity percentage on the H&E stained slide must be ≥10%					
3	The tumor surface area on the H&E stained slide must be circled .					
4	The circled tumor surface area on the H&E stained slide must be ≥4 mm²					
5	Pathology Report Attached					
6	6x unstained slides (tissue sections: 10 um thick) along with the matched circled H&E slide (tissue section: 4-5 μm thick) must be provided for the test *Note that tumor cellularity percentage refers to the percentage of viable tumor cells within the circled tumor area. <i>Please note that for tumors with less than 20 mm² surface area, it is likely that RNA input requirements will not be met.</i>					
7	Required clinical information: Please select the appropriate box.		This information is critical to establish the prognostic score.			
	Number of positive nodes	<input type="checkbox"/> 0			<input type="checkbox"/> 1-3	<input type="checkbox"/> ≥4
	Gross tumor size	<input type="checkbox"/> ≤2 cm			<input type="checkbox"/> >2 cm	
8	Number of tissue sections (tissue mounted FFPE slides) provided:	No. of H&E stained slides (with circled tumor surface area)				
		No. of matched unstained slides				
Reviewing Pathologist:						
Name (Printed):		Signature and date:				

For GCG use:

Sample received date and time:

Send samples to: Grafton Clinical Genomics, Building no. 503-201, The University of Auckland, 85 Park Rd, Grafton, Auckland 1023

Contact: Jason Copedo, j.copedo@auckland.ac.nz, gcgenomics@auckland.ac.nz, ph. +64 9 923 3432 (office)