



PATHOLOGY: Time Sensitive — Please Expedite

STUDY NAME / CODE _____

I. ASSAY / SUBMISSION TYPE

ASSAY: BREAST COLON SUBMISSION: FIRST RESUBMISSION — Associated Requisition _____

II. ORDERING PHYSICIAN INFORMATION

PRACTICE / INSTITUTION NAME _____

PHONE _____ FAX _____

ORDERING PHYSICIAN: Last / Surname _____ First Name _____

ORDERING PHYSICIAN'S EMAIL _____

ADDRESS _____

CITY _____ PROVINCE _____

POSTAL CODE _____ COUNTRY _____

CONTACT NAME AND EMAIL (if different from physician) _____

III. ADDITIONAL PHYSICIAN (Optional)

PRACTICE / INSTITUTION NAME _____

PHONE _____ FAX _____

ADDITIONAL PHYSICIAN / AUTHORIZED REPRESENTATIVE: Last / Surname _____ First Name _____

ADDITIONAL PHYSICIAN'S EMAIL _____

ADDRESS _____

CITY _____ PROVINCE _____

POSTAL CODE _____ COUNTRY _____

CONTACT NAME AND EMAIL (if different from physician) _____

IV. PATIENT INFORMATION

PATIENT: Last Name / Surname _____ First Name and Middle Initial _____

DATE OF BIRTH (Day / Month / Year) _____ GENDER Female Male PHONE / EMAIL _____

V. BILLING INFORMATION

Please select a billing method and complete the necessary information. Please read Section V on the reverse for full details.

SUBMITTING DIAGNOSIS _____

CREDIT CARD PAYMENT Name of Cardholder (As it appears on card) _____
Credit Card # _____ Expiration Date (Month / Year) _____

PRIVATE INSURANCE (Attach Front/Back copy of insurance card.) Do not use unless instructed by Genomic Health.
Insurance Company _____
Member ID _____ Group ID _____

WIRE TRANSFER Wire Reference Number _____
Date Transmitted _____

BILL LABORATORY / DISTRIBUTOR Restricted to contracted accounts on file at Genomic Health

VI. PHYSICIAN SIGNATURE & SPECIMEN STATUS

ORDERING PHYSICIAN SIGNATURE _____ DATE (Day / Month / Year) _____

X PRINT NAME _____

Please select specimen status for the Oncotype DX Cancer Assay selected above:

BREAST ASSAY: Node Negative Node Positive (1-3 Nodes)
 Micromets (pN1mi: 0.2-2.0mm) Node Positive (4+ Nodes)

COLON ASSAY: T4: Yes No Unknown
MSI-H or MMR-D: Yes No Unknown

EXCEPTION CRITERIA

By your signature you confirm that you have read and accept the terms stated on the reverse side. Specifically by signing this form you are stating that *either* 1) the patient meets the criteria stated in Section VI on the reverse side of this form OR 2) if the patient does not meet these criteria, that you have entered the reason(s) in the Exception Criteria space (provided to the right, at the end of this section). A Genomic Health representative may contact you should your patient not meet these criteria.

VII. PATHOLOGY INFORMATION

SUBMITTING LOCATION / HOSPITAL

Healthscope Pathology

PHONE **61 3 9538 2272** FAX **61 3 9543 5611**

SUBMITTING PATHOLOGIST: Last Name / Surname _____ First Name _____

ADDRESS _____

SUBMITTING PATHOLOGIST'S EMAIL _____

SPECIMEN IDENTIFICATION NUMBERS: _____ MULTIPLE PRIMARIES: Yes No

The Oncotype DX assay will be completed on the specimens in the order listed below. Only one specimen is typically required.

SPECIMEN IDENTIFICATION NUMBER	DATE OF SURGERY (Day / Month / Year)
1. _____	_____
2. _____	_____
3. _____	_____

SPECIMEN RETURN LOCATION (Not necessary if submitting slides) _____ PHONE _____ SPECIMEN RETURN CONTACT NAME _____

ADDRESS _____ CITY _____ STATE / PROVINCE _____ POSTAL CODE _____ COUNTRY _____

CONFIDENTIAL PATIENT INFORMATION