Breast Cancer Recurrence Test

EndoPredict®

Myriad Genetic Laboratories, Inc.
320 Wakara Way
Salt Lake City, Utah 84108
United States of America
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): 30 FEB 1900	
Gender: Female	Patient ID:
Last Name:	
First Name:	

BILLING INFORMATION

Payor ID: _____
or
Research #: _____
or
Voucher #: _____

ORDERING PHYSICIAN

Last Name:	Degree:
First Name:	Clinical ID:
Institution:	
Street, Nr:	
City, Postal Code:	Day Phone:
Country:	Fax:
E-mail: _____	

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

30 FEB 1900 Date (DD-MMM-YYYY)

SEND RESULTS TO (Optional – additional clinician can be listed to receive status updates and the patient's copy of the results)

Last Name:	First Name:	Institution:
Street, Nr:	City, Postal Code:	Country:
E-mail: _____		

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

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

Based on EndoPredict validation, accepted samples for the test are: ER+, HER2-, primary, invasive female breast tumors from patients who have not received systemic endocrine therapy and/or chemotherapy.

☐ Invasive Breast Cancer Age at Dx:_____ Date of biopsy/surgery (DD-MMM-YYYY): 30 FEB 1900

Tumor Size: ☐ pT1a (> 0.1 cm but ≤ 0.5 cm) ☐ pT1b (> 0.5 cm but ≤ 1 cm) ☐ pT1c (> 1 cm but ≤ 2 cm) ☐ pT2 (> 2 cm but ≤ 5 cm) ☐ pT3 (> 5 cm) ☐ pTx

Lymph Node Status: ☐ pN0 (zero positive nodes) ☐ pN1 (1 - 3 positive nodes; excluding pNmi) ☐ pN1mi (>0.2 mm and/or >200 cells but <2mm) ☐ pNx

ER: ☐ negative ☐ positive

HER2 Status: ☐ negative ☐ positive

☐ Patient has received chemotherapy for this diagnosis

SPECIMEN INFORMATION: TO BE COMPLETED BY PATHOLOGIST (Complete instructions are in the Instructions For Use (IFU) sheet).

Paraffin Block with at least 30% of Tumor Tissue:

For a specimen collection set please contact testkit@myriadgenetics.eu

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 _____ (minimum 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 30 FEB 1900 Date (DD-MMM-YYYY)

INTERNAL USE ONLY: Bill Institution BIE _____ .

TISSUE RETURN

I request the remaining tissue to be returned.*

Name: _____

Address: _____

_____

E-mail / Phone: _____

* If an address is not provided, any tissue remaining after testing will be discarded and not be returnable.

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

ENDO_TRF_24_01_19_EN_editable