A molecular diagnostic test to determine prostate cancer aggressiveness

Prolaris®

myriad® WHEN DECISIONS MATTER

Myriad Genetic Laboratories, Inc.
320 Wakara Way
Salt Lake City, Utah 84108
United States of America

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: MALE | PATIENT ID:

LAST NAME:

FIRST NAME:

BILLING INFORMATION

PAYOR ID:_____

or

RESEARCH #:_____

or

VOUCHER #:_____

ORDERING PHYSICIAN

LAST NAME: | DEGREE: Prof.

FIRST NAME: | CLINICAL ID:

INSTITUTION:

STREET, NR:

CITY, POSTAL CODE:

COUNTRY: | DAY PHONE:

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

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.

TEST REQUESTED (NOTE: If patient has received pelvic radiation and/or androgen deprivation prior to his biopsy or prostatectomy, the Prolaris test should not be ordered)

☐ PROLARIS BIOPSY (Patient had biopsy only; no treatment to date)

Prostate Cancer: Age at Dx: _____

Pre-Biopsy PSA: _____

Date of Biopsy (DD-MMM-YYYY): 30 FEB 1900

Biopsy Gleason Score:

Primary Grade:	+	Secondary Grade:	= Gleason Score
☐1	+	☐1	
☐2	+	☐2	
☐3	+	☐3	= 0
☐4	+	☐4	
☐5	+	☐5	

Stage: ☐T1a ☐T1b ☐T1c ☐T2a ☐T2b ☐T2c ☐T3a ☐T3b ☐T4

Biopsy Cores:

Total number of cores taken: _____

Total number of positive cores: _____

REQUIRED DATA FOR PROLARIS COMBINED SCORE

REQUIRED TISSUE FOR TEST: BIOPSY

☐ PROLARIS PROSTATECTOMY (Patient had prostatectomy already)

Prostate Cancer: Age at Dx: _____

Pre-Surgical PSA: _____

Date of Surgery (DD-MMM-YYYY): 30 FEB 1900

Prostatectomy Gleason Score:

Primary Grade:	+	Secondary Grade:	= Gleason Score
☐1	+	☐1	
☐2	+	☐2	
☐3	+	☐3	= 0
☐4	+	☐4	
☐5	+	☐5	

Positive Margins: ☐ Yes ☐ No

Extracapsular Extension: ☐ Yes ☐ No

Seminal Vesicle Invasion: ☐ Yes ☐ No

Positive Lymph Node(s): ☐ Yes ☐ No ☐ Not Assessed

REQUIRED DATA FOR PROLARIS COMBINED SCORE

REQUIRED TISSUE FOR TEST: PROSTATECTOMY TISSUE

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

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

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

☐ Tissue Slides enclosed (4-5 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

30 FEB 1900 Date (DD-MMM-YYYY)

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.

INTERNAL USE ONLY: Bill Institution BIE _____.

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

PROL_TRF_13_08_18_EN_EDIT