Test Request Form

1. Ordering Physician:

Hospital*: _____

Department: _____

Name (Last, First)*: _____

Address: _____

ZIP: _____ City: _____

Country: _____

Phone: _____

Email*: _____

Specialty: ☐ Surgery ☐ Oncology ☐ Pathology

Additional Physician report/recipient (email): _____

Place Specimen Label Here
From Specimen Kit Box

Specimen collection date ☐☐ - ☐☐ - ☐☐ (D D - M M - Y Y)

Specimen Type: ☐ Block/slide ☐ Fresh

Tumor Type: ☐ Invasive Breast Cancer:

☐ Right Breast ☐ Left Breast

☐ Other (Specify): _____

☐ Colon Cancer:

☐ Stage II ☐ Stage III

T-number/pathology number: _____

agendia®
decoding cancer.

Science Park 406
1098 XH Amsterdam
phone: +31 20 462 1510
fax: +31 20 462 1505
customerservice@agendia.com
www.agendia.com

2. Gene Expression Profiles: Please select one of the following*

☐ Send and Hold

BREAST CANCER

☐ **SYMPHONY™ Personalized Breast Cancer Genomic Profile**

Comprehensive Analysis of Gene Expression:

☐ MammaPrint® Breast Cancer Recurrence Assay

☐ BluePrint® Molecular Subtyping Assay

☐ TargetPrint® ER/PR/HER2 Expression Assay

TargetPrint Genes: ☐ ER ☐ PR ☐ HER2

GENOMIC PROFILING FOR THERAPY OPTIONS

☐ TheraPrint for Breast Cancer

☐ TheraPrint for Colorectal Cancer

INDIVIDUAL MARKERS (PARAFFIN BLOCK/SLIDES)

☐ **BRAF Mutation Analysis** ☐ **KRAS Mutation Analysis**

☐ **EGFR Mutation Analysis** ☐ **PIK3CA Mutation Analysis**

COLON CANCER

☐ **SYMPHONY™ Personalized Colon Cancer Genomic Profile**

Comprehensive Analysis of Gene Expression:

☐ ColoPrint (Fresh)

3. Patient Information

Name (Last, First): _____

Address: _____ Zip: _____ City: _____

Country: _____ Date of birth: ☐☐ - ☐☐ - ☐☐ (D D - M M - Y Y) Sex: ☐ M ☐ F

Insurance Company Patient * : _____ **Insurance Number Patient * :** _____

4. Pathologist Information

Mandatory fields in case a block is sent in and needs to be returned.

Name (Last, First): _____

Hospital or Reference Lab: _____

Phone: _____ Fax: _____

Address: _____

ZIP: _____ City: _____

Country: _____

Report Delivery
Email Address: _____

5. Physician Authorization: *mandatory field

I am treating this patient and have concluded that the test(s) I have ordered are medically necessary for treatment of this patient because I anticipate that this test(s) will provide prognostic and predictive information which has not been obtained already. This order form is part of the medical record, is consistent with other entries in the record and accurately describes the reason(s) I am ordering this test(s).

Signature of Ordering Physician (See General Terms and Conditions)

Date

*required fields

©2013 Agendia M-ROW-008-V1