TEST REQUEST FORM

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agendia
decoding cancer

ORDERING PHYSICIAN TO COMPLETE

SECTION 1. PATIENT INFORMATION

Patient Name, Last, First

Address

Postal Code | City | Country

DD-MMM-YYYY
Date of Birth

Gender: ☐ Female ☐ Male

Insurance Company Patient*:

Insurance Number Patient*:

SECTION 2. SPECIMEN INFORMATION

Place sample identification label (AG#) from specimen kit box here

Collection Date DD-MMM-YYYY **Specimen Type** ☐ FFPE Block* ☐ FFPE Slides

Tumor Type ☐ Invasive Breast Cancer ☐ Other (Specify)

Pathology Number **Tumor Stage**

SECTION 3. CLIENT INFORMATION

Ordering Physician Details

Hospital / Institution Name

Department

Physician Name: Last , First

Address

Postal Code | City | Country

Email

SECTION 4. PHYSICIAN SIGNATURE

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

Print Name

Signature of Ordering Physician (see general Terms and Conditions) Date

SECTION 5. TEST REQUESTS

☐ **Agendia Breast Cancer Test Suite**
(includes MammaPrint® and BluePrint®)

☐ **MammaPrint, 70 Gene Breast Cancer Recurrence Assay**

☐ **BluePrint, 80 Gene Molecular Subtyping Assay**

If this request is part of a clinical study, please indicate the study code here (sticker, stamp or text):

SECTION 6. PATHOLOGY INFORMATION

Hospital or Reference Lab

Contact Name (Last, First)

Address

Postal Code | City | Country

Phone | Fax

Email address for report delivery

*** THIS SECTION IS REQUIRED FOR FFPE BLOCK SUBMMISSIONS AND BLOCK RETURN PROCESS**

Additional Comments