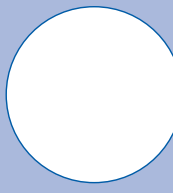


Laboratory use only

Identify	PATIENT DETAILS UR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Patient status at the time of the service when the specimen was collected.																		
	SURNAME GIVEN NAMES DOB / / WARD GENDER ADDRESS		<table border="0"> <tr> <td>Yes</td> <td>No</td> <td>or</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>a) private patient in a private hospital or approved day hospital facility</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>b) a private patient in a recognised hospital</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>c) a public patient in a recognised hospital</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>d) an outpatient of a recognised hospital</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>			Yes	No	or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a) private patient in a private hospital or approved day hospital facility	<input type="checkbox"/>	<input type="checkbox"/>	b) a private patient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>	c) a public patient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>	d) an outpatient of a recognised hospital
Yes	No	or																			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																			
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c) a public patient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>																			
d) an outpatient of a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>																			
Situation Background Assessment	REQUESTING PRACTITIONER Provider number: SURNAME & FIRST NAME: ADDRESS:		Medicare number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Expiry date / I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner. I understand my medical practitioner may have requested testing that is not reimbursed by Medicare and also not covered by my private health insurance. If there is a cost involved, this has been explained to me, and I agree to accept responsibility for the payment of test fees Patient's signature Date / /																		
	CLINICAL DETAILS		TISSUE FOR TESTING Laboratory Number: Block Selected: Tumour percentage: Collection Date:																		
Request	TESTS REQUESTED: LUNG CANCER		<input type="checkbox"/> EGFR <input type="checkbox"/> EGFR, KRAS																		
	COLORECTAL CANCER		<input type="checkbox"/> KRAS, NRAS, BRAF																		
	MELANOMA		<input type="checkbox"/> BRAF																		
	THYROID CANCER		<input type="checkbox"/> BRAF, NRAS																		
	PANCREATIC CANCER		<input type="checkbox"/> KRAS																		
	NEURO-ONCOLOGY GBM		<input type="checkbox"/> MGMT <input type="checkbox"/> IDH1/IDH2 <input type="checkbox"/> ***1p19q deletion																		
	Pilocytic Astrocytoma, LGG		<input type="checkbox"/> BRAF V600E <input type="checkbox"/> BRAF-KIAA1549																		
	DIPG, HGG		<input type="checkbox"/> Histone H3K27M + G34R																		
	PAEDIATRIC CANCER *Ewing Sarcoma		<input type="checkbox"/> EWS-FLI1, EWS-ERG																		
	*Rhabdomyosarcoma		<input type="checkbox"/> PAX3/7-FKHR																		
*Desmoplastic Small Round Cell Tumour		<input type="checkbox"/> EWS-WT1																			
**Rhabdoid Tumour/ATRT		<input type="checkbox"/> SMARCB1																			
Wilms Tumour		<input type="checkbox"/> 11p15 <input type="checkbox"/> *1p16q deletion																			
*Will also require cytogenetic/FISH investigation **For complete testing, fresh tissue is required ***A paired blood specimen is also required for this test																					
OTHER (please specify)																					
Doctor's Name (print).....Sign.....Date.....Pager.....Phone.....Fax.....																					

MOLECULAR TESTS GENETICS AND MOLECULAR PATHOLOGY

Test name/Gene Name	Condition/Tumour	Fee	Medicare Rebate
EGFR mutations (exon 18-21)	Lung Cancer	\$397.35	Item 73337
KRAS and NRAS	Colorectal Cancer	\$362.60	Item 73338
NRAS	Other than colorectal cancer	\$230.95	N/A
BRAF 600/601 mutations	Melanoma	\$230.95	Item 73336
BRAF 600/601 mutations	Other than melanoma	\$230.95	N/A
1p19q co-deletion	Oligodendroglioma	\$404.00	N/A
BRAF-KIAA1549 fusion	Juvenile Pilocytic Astrocytoma	\$480-\$578.00	N/A
SMARCB1 gene	Atypical Theratoid Rhabdoid Tumour	\$482.00 (Sanger) \$330.00 (MLPA)	N/A
Histone H3 K27M and G34R Mutations	Diffuse Intrinsic Pontine Glioma and Glioblastoma (paediatric)	\$282.00	N/A
MGMT methylation	Glioblastoma	\$305.50	N/A
IDH1 (R132) and IDH2 (R172) mutations	Glioma	IDH1 only \$282.00 IDH2 only \$282.00 IDH1 & IDH2 \$432.00	N/A
EWS-FLI1, EWS-ERG1	Ewing's Sarcoma	\$480-\$578.00	N/A
EWS-WT1	Desmoplastic Small Round Cell Tumour	\$480-\$578.00	N/A
PAX3/7-FKHR	Alveolar Rhabdomyosarcoma	\$480-\$578.00	N/A
1p16q co-deletion	Wilms Tumour	\$440.00	N/A
11p15 (methylation)	Wilms Tumour	\$612.00	N/A

Privacy note: The information provided will be used to assess any Medicare benefits payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update environment records. Its collection is authorised by the provisions of the Health Insurance Act 1973. The information may be disclosed to the Department of Health or to a person in the medical practice associated with this claim, or as authorised/required by law.