

General Referral Form

Patient Information

Surname:

First name:

NHI:

Sex at birth (*please circle*): M / F

DOB:

Sample Details and Clinical Information

Specimen type (*please circle*): FFPE / blood / bone marrow / trephine / other:

Origin of tissue:

Date and time collected:

Referring laboratory reference:

Supporting clinical information:

****Please attach pathology report****

Test/s Requested

Molecular Oncology: (*min. 12 slides*)

MassARRAY mutation testing:

- | | |
|--------------------------------------------------------------|----------------------------------|
| <input type="checkbox"/> Colon | <input type="checkbox"/> GIST |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Gynae |
| <input type="checkbox"/> Melanoma | <input type="checkbox"/> IDH 1/2 |
| <input type="checkbox"/> MLH1 Methylation | |
| <input type="checkbox"/> Other (<i>please state</i>) _____ | |
| <input type="checkbox"/> CGH Array (Microarray) | |

FISH: (*min. 2 slides/probe*)

Probe/s: _____

Reporting Information

Referring Dr:

NZMC#:

Contact #:

Email:

Signature:

Date:

Copy to Dr:

Email:

Billing Information

Please indicate method of payment: (Invoice will be emailed to the referring doctor if this section is blank)

- Invoice Health NZ: _____ Purchase Order # (required) _____
- Invoice Private Clinic: _____ Billing contact: _____
- Private patient to pay directly (*please attach IGENZ Consent and Payment Form*)

Supplementary Information (eg tumour content)

Please refer to our website for specific sample requirements: www.igenz.co.nz