Genomic Diagnostics
LEADING THE WAY TO IMPROVE HEALTH

Test Request Form

HNPCC (Lynch Syndrome)

GD Lab Case ID
(Internal Use Only)
MD _____
Received: _____

To optimize the accuracy of the personalised Cancer Risk and Management Tool for the patient, please complete entire form to avoid delays.

1. REQUESTING PHYSICIAN INFORMATION

Full Name:

Address:

City: | Postcode:

Email *(<**IMPORTANT**> for report notification)*:

Phone: | Fax:

Signature of Requesting Physician: | Date:

or/and Genetic Counsellor Information *(recommended)*

Full Name:

Address:

City: | Postcode:

Email *(<**IMPORTANT**> for report notification)*:

Phone: | Fax:

Send a copy of the report also to the Genetic Counsellor? ☐ Yes ☐ No

2. PATIENT INFORMATION

Last Name: | ☐ Male ☐ Female

First Name: | Phone:

Reference/Medical Record Number: | Date of Birth: DD / MM / YYYY

Ancestry *(check all that apply)*

☐ Ashkenazi Jewish ☐ Asian ☐ Aboriginal Australia ☐ Near East/Middle East
☐ European ☐ African ☐ Native New Zealand ☐ Other: _____

Patients Personal History of Cancer *(check all that apply)*

☐ No Personal History of Cancer

☐ Colorectal Invasive Age of Diagnosis:_____ ☐ MSI-H Histology ☐ Braf(-) ☐ LOE_____ protein(s)
☐ Mucinous ☐ Signet Ring ☐ Medulary Growth Pattern
☐ Tumour Infiltrating Lymphocytes ☐ Crohn's like Lymphacytic Reaction

☐ Adenomatous Polyps Age of Diagnosis:_____ Cumulative #:☐ 1 ☐ 2-5 ☐ 6-9 ☐ 10-19 ☐ 20-99 ☐ 100+

☐ Endometrial/Uterine Age of Diagnosis:_____

☐ Other Cancer(s) & Age of Diagnosis:

☐ Tumour Pathology Report Attached

Family History of Cancer

☐ No Family History ☐ Family History

Relationship	Maternal	Paternal	Cancer	Adenoma No.	Age at Diagnosis
e.g. Aunt	☐	☐	Endometrial		48
	☐	☐			
	☐	☐			

3. TEST REQUESTED

☐ *MLH1, MSH2 and MSH6* ☐ Single Gene Test [Specify_____]

☐ Gene Panel ☐ Predictive [Specify variant & attach proband report:_____]

Sample Type

☐ Blood ☐ Buccal Swab ☐ DNA [Concentration: _____ µg/mL]

4. PAYMENT

OPTION 1 ☐ Institutional | **OPTION 2** ☐ Private *(Complete Private Payment Form)*

Institution:

Contact Person:

Address: | Post Code:

Email: | Phone:

Fax: | ☐ Purchase Order No: | Contract No:

5. Once Completed Fax to Genomic Diagnostics on +61 3 9417 6863 or Return With Kit