NCGM — by Neuberg —

TEST REQUISITION FORM

ONCOLOGY

PATIENT DETAILS

(In BLOCK letters)

Full Name

Age (Y Y / M M) Gender ☐ M ☐ F Ethnicity

E-mail ID Contact No.

Address

City / State / Postal Code Country

TREATING PHYSICIAN INFORMATION

Facility Name

Physician Name

Facility Address

City / State / Postal Code Country

E-mail ID Contact No.

Additional Physician to be Copied(optional)

Facility Name

E-mail ID Contact No.

CURRENT DIAGNOSIS/ PATIENT HISTORY

Diagnosis : ☐ NSCLC ☐ Melanoma ☐ Colorectal Adenocarcinoma ☐ Ovarian ☐ Breast ☐ Other .....

Disease Status (select as many as apply) : ☐ Metastatic ☐ Recurrent ☐ Refractory ☐ Relapse

Subtype Stage

Radiological findings : .....

Immunohistochemistry study report : .....

ER, PR, Her2 neu status : .....

Earlier genomic tests /Targeted Therapies/ (Please mention the results)

.....

.....

Please attach the below reports to the TRF : (if Available)

Attachments :

☐ Copy of recent pathology /cytology reports including (if available)

☐ Test results from all other Molecular Diagnostic Assays by FISH, IHC, or other genetic assays, e.g.,ER, PR, HER2, EGFR, KRAS,etc.

Neuberg Centre for Genomic Medicine (NCGM)

Phone: +91-6357244307, 079-61618111 | Email: contact@ncgmglobal.com | Web: www.ncgmglobal.com

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TEST REQUISITION FORM

TEST SELECTION

(Sample Type)

OncoCEPT Solid (*FFPE block containing tumor tissue) **OncoCEPT Liquid** (*10ml Whole blood EDTA in streck tube)

OncoCEPT Comprehensive (*FFPE block containing tumor tissue) **MSI** (*FFPE blocks with slides + EDTA blood)

ColoComprehensive (MSI+BRAF+KRAS+NRAS) (*FFPE block containing tumor tissue) **MMR by IHC**

PDL-1 test **PDL1 SP142** **PDL1 SP 263** **PDL1 22C3 DAKO** (#Drug details)

OncoCEPT Solid + PDL1 **OncoCEPT Solid Comprehensive + PDL1**

BRCA1 & BRCA2 gene sequencing **Inherited cancer panel**

Other test : Description of test & sample type .....

.....

In case of inadequate tissue, please tick the test which test would you like us to do first:

OncoCEPT Solid **OncoCEPT Solid Comprehensive** **PDL-1**

Drug details for PDL-1 IHC

(PDL-1 IHC indicated in patients with specific tumor type in order to predict their responses to treatment with PDL-1 inhibitors. The specific PDL-1 clone scoring method and eligibility requirements are dependent on the tumor type, stage of malignancy, previous treatment outcomes and specific PDL-1 inhibitors being considered)

Tick	Clone	Drug
	Sp263	Nivolumab (opdivo)
	Sp263	Durvalumab (imfinzi)
	Sp142	Atezolilumab (Tecentriq)
	Sp142	Atezolilumab (Tecentriq)
	Sp142	Atezolilumab (Tecentriq) Plus nab- paclitaxel (Abaxane)
	22C3 DAKO	Pembrolizumab (Keytruda)

SAMPLE DETAILS

Date of Collection (MM/DD/YYYY) ..... **Specimen ID** .....

☐ **FFPE of tumour tissue (BIOPSY fixed in 10% Neutral buffered formalin)**
Specimen Site .....
No. of paraffin blocks and details: .....
Please mention block number on which test has to be performed .....

☐ **Body Fluid (At least 1 litre) or cell block**

☐ **FFPE BLOCK of tumor tissue (BIOPSY fixed in 10% Neutral buffered formalin) with HE stained slide**
Specimen Site .....

☐ **Unstained poly L lysine coated slides**

Cold ischaemia time - ..... **mins or hrs or unknown (As time of transfer of tissue after removal from body upto immersion into the 10% neutral buffered formalin)**

Time Formalin fixation (10% neutral buffered formalin): known: ..... **hours / unknown**

(Note : Neuberg Center for Genomic Medicine (NCGM) chooses the best block(s) based on initial morphologic assessment for further IHC PDL-1 study . It makes all efforts are made to preserve and make sure not to exhaust the tissue entirely under study. However in small thin/tiny specimen, there is a possibility of exhausting the tissue to ensure quality and reliability of the results.)

(CAP/ASCO recommendation: for breast markers and GI Her2neu, the cold ischemic time should be < 01 hours and optimal fixation for ER/PgR/Her2Neu in 10% buffered formalin MUST be 06 to 72 hours)

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TEST REQUISITION FORM

Family History of any Cancer

Sr. No.	Type of Cancer	Age of disgnosis	Relationship with patient	Mother's or father's side	Histopathology / genetic test reports (if available)

Billing Information

Self pay in cash (reference) _____

Electronic payment (reference) _____

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PHYSICIAN CONSENT

I certify that I am patient's treating physician and I consent that this test will aid in patient's ongoing treatment. I have explained the patient about nature and purpose of testing. Patient has given his consent to me for Neuberg Center of Genomic Medicine to

(1) Perform tests mentioned here.
(2) Retain the test results.
(3) De-identify the test report/ result for future research purpose and publication.

I authorize Neuberg Center of Genomic Medicine to perform most appropriate test based on submitted histopathology report.

Signature	Printed Name	Date: DD/MM/YY

PATIENT CONSENT

I certify that I have been explained by my physician that this test will aid in my ongoing treatment/management. I have been explained about nature and purpose of testing. I give my consent to Neuberg Center of Genomic Medicine to

(1) Perform tests mentioned here.
(2) Retain the test results.
(3) De-identify the test report/ result for future research purpose and publication.

I authorize Neuberg Center of Genomic Medicine to perform most appropriate test based on submitted histopathology report.

Signature	Printed Name	Date: DD/MM/YY