ST VINCENT'S PATHOLOGY
A SERVICE OF ST VINCENT'S HOSPITAL MELBOURNE

Molecular Oncology Test Request Form

RCPA The Royal College of Pathologists of Australasia

NATA ACCREDITED FOR TECHNICAL COMPETENCE

Form: ANAT-MOL-F-201 v12

ACCREDITED LABORATORY NUMBER: 2531

PATIENT DETAILS (IN BLOCK LETTER)

Family Name: .....

Given Name: .....

Address: .....

..... **Postcode:** .....

DOB: ...../...../..... **Gender:** .....

Contact Phone No.: .....

REQUESTING PRACTITIONER (IN BLOCK LETTER)

Family name: .....

Given Name: .....

Address: .....

..... **Postcode:** .....

Provider No.: .....

Phone: ..... **Fax:** .....

Email (Required): .....

CLINICAL HISTORY

HOSPITAL STATUS OF PATIENT AT SPECIMEN COLLECTION OR DATE OF SERVICE

- ☐ Private patient in private hospital or approved day hospital facility
- ☐ Private patient in a recognised hospital
- ☐ Public patient in a recognised hospital
- ☐ Outpatient of a recognised hospital

INVOICING PROCEDURE

- ☐ Bill Patient (Complete "**Patient Authorisation Section**" below)
- ☐ Bill Referring Department: **Specify** _____
- ☐ Bill Laboratory: **Specify** _____
- ☐ Bulk Bill (Provide **Medicare Number** below)

Important: Bulk billing applies only for the eligible tests marked with *.
Specify billing party above for any non-Bulk billing tests if requested.

11 DIGIT MEDICARE NUMBER

☐☐☐☐☐☐☐☐☐☐ ☐

MEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973) PRACTITIONERS USE ONLY
TO BE COMPLETED BY PERSON ASSIGNMENT BENEFITS FOR THE SERVICES ON THE FORM
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.

Patient Signature: ..... **Date:** .....

Practitioner's use only (reason patient cannot sign): .....

PATIENT AUTHORISATION

I understand that my medical practitioner has requested a test that that is **not** covered by Medicare or not covered/partly covered by my private health fund.
I agree to accept responsibility for the full payment of the fees for this test:

Signature: ..... **Date:** .....

Credit Card Number:

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry Date: ☐☐/☐☐ **CCV:** ☐☐☐

Card Type: **MasterCard** ☐ **VISA** ☐ **Amount: $** .....

TESTS REQUESTED

(Note: Bulk billing tests for eligible patients are marked with *)

LUNG CANCER (NSCLC)	
Next Generation Sequencing (NGS)	
☐ NGS lung DNA panel (Medicare item: 73337)* (NGS panel including **EGFR, KRAS & BRAF**)	**$ 397.35***
☐ NGS **EGFR T790M** DNA panel (Medicare item: 73351)*	**$ 397.35***
☐ NGS lung RNA fusion panel (Selected **ALK, NTRK1, RET & ROS1 fusions**)	**$ 356.00**
Immunohistochemistry (IHC)	
☐ ALK IHC (Medicare item: 72846)*	**$ 59.60***
☐ ROS1 IHC (Medicare item: 72846)*	**$ 59.60***
☐ PD-L1 IHC (Medicare item: 72814)*	**$ 74.50***
☐ **Perform relevant FISH if IHC is positive**	
Fluorescence In Situ Hybridisation (FISH)	
☐ ALK FISH (Medicare item: 73341)*	**$ 400.00***
☐ ROS1 FISH (Medicare item: 73344)*	**$ 400.00***
☐ RET FISH	**$ 400.00**
COLORECTAL CANCER	
☐ NGS colorectal DNA panel (Medicare item:73338)* (NGS panel including **KRAS, NRAS & BRAF**)	**$ 362.60***
MELANOMA	
☐ NGS melanoma DNA panel (Medicare item: 73336)* (NGS panel including **BRAF, NRAS, GNAQ & GNA11**)	**$ 230.95***
NEURO-ONCOLOGY	
☐ NGS IDH1/IDH2 DNA panel (Medicare item: 73372)*	**$ 340.00**
☐ 1p/19q FISH (Medicare item: 73371)*	**$ 340.00**
☐ EGFR amplification by FISH	**$ 325.00**
THYROID CANCER	
☐ NGS thyroid DNA panel	**$ 328.00**
☐ NGS thyroid RNA fusion panel	**$ 356.00**
GASTROINTESTINAL STROMAL TUMOUR (GIST)	
☐ NGS GIST DNA panel (NGS panel including **KIT & PDGRFA**)	**$ 328.00**
BREAST and GASTRIC CANCER	
☐ HER2 FISH (Medicare item: 73332)*	**$ 315.40***
22 GENE NGS DNA PANEL	
☐ Gene list available on request	**$ 328.00**
50 GENE NGS DNA PANEL	
☐ Gene list available on request	**$ 398.00**

I understand that if the cost of requested testing is not covered under Medicare, payment for tests performed is the responsibility of the requesting doctor or department, unless a signed patient consent to pay is provided.

REQUESTING DOCTOR'S SIGNATURE: _____

❖ **SAMPLE REQUIREMENTS (Send the following items in a padded bag):**

- For NGS DNA panel: 10x unstained 5 µm sections on uncoated slides
- For NGS RNA fusion panel: **Paraffin block** is required
- For IHC: 2x unstained 4 µm sections on coated slides
- For FISH: 5x unstained 5 µm sections on coated slides

AND

- This test form completed in full
- A copy of the original pathology report

ORIGINAL PATHOLOGY LAB: _____

BLOCK IDENTIFICATION NUMBER: _____

❖ **SHIPPING ADDRESS:**
Molecular Laboratory, Anatomical Pathology Department
Level 2, Main Building A, St Vincent's Hospital
41 Victoria Parade, Fitzroy VIC 3065

❖ **CONTACT DETAILS:**
Phone: 03 9231 1049 | **Fax**: 03 9231 4580 | **Email**: Molecular@svha.org.au