



# Prosigna<sup>®</sup> | Request Form

## FOR THE DOCTOR

This test should be requested by the specialist responsible for managing the patient's breast cancer treatment.

### Patient details

Name: \_\_\_\_\_  
Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: **Female**  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone (mobile): \_\_\_\_\_

## Clinical information **REQUIRED**

Unless the laboratory is advised to the contrary, it is assumed that the patient has post-menopausal breast cancer that is ER+ and HER2 negative. Please include a copy of the histology and immunochemistry reports with this request form.

**The following information is required to determine the risk score. Testing cannot proceed without this information:**

Number of involved nodes: Gross tumour size:  
☐ 0 ☐ 1-3 ☐ ≥ 4 ☐ ≤ 2 cm ☐ > 2 cm  
☐ Histology and immunochemistry report must be included.

Additional Clinical Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Holding laboratory and sample details

If these details are left blank, Sonic Genetics will assume that the lab providing the histology report is also holding the sample required for this test. **Sample must be breast tissue.**

Holding laboratory details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Holding laboratory reference number: \_\_\_\_\_  
Sample block number: \_\_\_\_\_  
Patient name (as per block): \_\_\_\_\_  
\_\_\_\_\_  
Date of birth (as per block): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Requesting Doctor

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Provider No: \_\_\_\_\_

By signing this form I confirm that I have the consent of the patient to request Prosigna Breast Cancer Gene Signature Assay, and that the patient is aware they will need to pre-pay for this test.

 **CLINICIAN SIGNATURE** Date \_\_\_\_\_

## Copy reports to

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_

## FOR THE PATIENT

### This test must be pre-booked.

Prosigna is a specialist service that requires pre-payment to initiate the testing process and ensure the best test outcomes.

The price of the test is listed on our website.

To finalise the order of your Prosigna test, please contact us on 1800 010 447 to complete your booking. You will need to have this form at hand. **Medicare benefits do not apply.**

### Patient consent

I confirm I have been informed about the purpose, scope, and performance of the Prosigna test by my doctor, Prosigna patient literature, and/or the Sonic Genetics website. I understand that the test is performed from breast tissue collected previously, that the sample will be requested by Sonic Genetics from the holding laboratory for this test, and that the result should be reviewed by my doctor in light of other findings. I have had the opportunity to ask questions and discuss these issues with my doctor, and understand that I can request further information. I consent to the Prosigna Test being performed and agree to prepay the fee for this test.

 **PATIENT SIGNATURE** Date \_\_\_\_\_

To finalise the request for your patient, please fax this complete request form to (02) 9855 5446. You can also email this request to [info@sonicgenetics.com.au](mailto:info@sonicgenetics.com.au). Sonic Genetics will begin the sample retrieval process with the holding laboratory on receipt of full payment of the test fee. Medicare benefits do not apply.

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