

FOR LABORATORY USE ONLY - ENDOPREDICT

SCMD Lab No:	Received by:	Tumour area >30%? accept / reject	Macro required? yes / no	Received (Date/Time)
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ORDERING INDIVIDUAL (e.g. Oncologist/Surgeon/Pathologist)

Name:	Email:
Phone:	Hospital/Centre:

DESTINATION(S) FOR ANALYSIS REPORT (Results may be delayed if not completed)

Required Method(s) for Report Delivery (please tick all that apply):			Post <input type="checkbox"/>	Fax <input type="checkbox"/>	Email <input type="checkbox"/>
Address:	Result Fax number(s):	Results e-mail(s):			

INVOICING DETAILS (Results may be delayed if not completed in full)

Contact name:	Full Organisation Name and Postal Address (inc. postcode):
Phone:	
Email:	

Note: An authorisation code is mandatory if providing private medical insurance details.

PATIENT / SAMPLE DETAILS (At least 3 unique identifiers are mandatory)

Surname:	Forename(s):	DOB (DD/MM/YY):	Hospital Number:
Supplied Sample Format(s):	Sample Identifier Number(s):	Other Requester Ref (if applicable):	
Number of blocks:	Number of slides:		

PATHOLOGICAL INFORMATION – CRITICAL

PLEASE NOTE: THE OVERALL RECURRENCE RISK SCORE REPORTED BY THE ENDOPREDICT ASSAY INCORPORATES KEY PATHOLOGICAL INFORMATION INTO THE CALCULATION. THIS INFORMATION **MUST** EITHER BE PROVIDED **IN FULL** (BELOW), **OR** LEFT BLANK AND THIS FORM BE SUPPLIED WITH COPIES OF **ALL** RELEVANT PATHOLOGY REPORTS FROM WHICH THE INFORMATION CAN BE OBTAINED. **IN EITHER CASE THE DECLARATION MUST BE COMPLETED & SIGNED, OTHERWISE SAMPLES WILL BE RETURNED UNTESTED.**

ER Status:	positive <input type="checkbox"/>	negative <input type="checkbox"/>	Tumour Size:	T1a <input type="checkbox"/>	T1b <input type="checkbox"/>	T1c <input type="checkbox"/>	T2 <input type="checkbox"/>	T3 <input type="checkbox"/>
HER2 Status:	positive <input type="checkbox"/>	negative <input type="checkbox"/>	Lymph Node Status:	0 <input type="checkbox"/>	1-3 <input type="checkbox"/>	4-10 <input type="checkbox"/>	>10 <input type="checkbox"/>	

I hereby confirm that I have obtained informed consent from the patient and believe that Endopredict is a medically appropriate test for their treatment management. I further confirm that (tick one of the following):

- All of the information I have provided above is correct and I understand that any errors may affect the test outcome/validity.
- The required pathological information (ER/HER2 receptor status, tumour size, nodal status) may be obtained from the pathology report(s) detailed below, of which I have supplied full copies. I understand that any additional information contained in any other reports which I have not supplied/stated may affect the test outcome/validity.

Pathology report ID number(s):	Name(s) of reporting Pathologist(s):		
Signature:	Print Name:	Position (e.g. Surgeon):	Date: