EndoPredict®
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FOR LABORATORY USE ONLY - ENDOPREDICT						
SCMD Lab No:		**Received by:**		**Tumour area >30%?** accept / reject	**Macro required?** yes / no	**Received** (Date/Time)

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** ☐ **Fax** ☐ **Email** ☐

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 ☐ negative ☐	**Tumour Size:**	T1a ☐ T1b ☐ T1c ☐ T2 ☐ T3 ☐
HER2 Status:	positive ☐ negative ☐	**Lymph Node Status:**	0 ☐ 1-3 ☐ 4-10 ☐ >10 ☐

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:**