Prolaris®
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SARAH CANNON
Molecular Diagnostics
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FOR LABORATORY USE ONLY - PROLARIS						
SCMD Lab No:		**Received by:**		**Tumour cellularity >50%?** 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** ☐ **Email** ☐	
Address:	**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:			

CLINICAL INFORMATION

PLEASE NOTE: THE OVERALL OUTCOME OF THIS TEST IS GENERATED BY COMBINING KEY CLINICAL INFORMATION WITH BIOLOGICAL DATA – FULL AND ACCURATE COMPLETION OF THE FOLLOWING SECTION IS CRITCAL.

Clinical Stage (Based on DRE)**:**	T1a ☐	T1b ☐	T1c ☐	T2a ☐	T2b ☐	T2c ☐	T3a ☐	T3b ☐	T4 ☐

Pre-biopsy total PSA (ng/mL)**:**		**Total num. sites biopsied:**	**Total num. sites with +ve cores(s):**

Highest Gleason score on current biopsy Primary grade + Secondary grade = Gleason score					**Pre-biopsy total PSA:** (ng/mL)		**Date of biopsy:** dd/mm/yyyy
	+		=	0	**Prostate volume:** (cubic cm)		***Or*** **dimensions:** (l x w x h in cm)

I hereby confirm that:

☐ I have obtained informed consent from the patient and believe that Prolaris is a medically appropriate test for their treatment management.

☐ This patient has **NOT** received cancer-reducing therapy prior to biopsy. Please note that prior therapy will invalidate the analysis, and the test must not be performed.

☐ All of the information I have provided above is correct and I understand that any errors may affect the test outcome/validity.

Signature:	**Print Name:**	**Position** (e.g. Surgeon):	**Date:**