

ONCOLOGY**PATIENT DETAILS**

(In BLOCK letters)

Full Name Age ^Y ^Y / ^M ^MGender M FEthnicity E-mail ID Contact No. Address City / State / Postal Code Country **TREATING PHYSICIAN
INFORMATION**Facility Name Physician Name Facility Address City / State / Postal Code Country E-mail ID Contact No. Additional Physician to be Copied(optional) Facility Name E-mail ID Contact No. **CURRENT DIAGNOSIS/
PATIENT HISTORY**Diagnosis : NSCLC Melanoma Colorectal Adenocarcinoma Ovarian Breast
 OtherDisease Status (select as many as apply) : Metastatic Recurrent Refractory RelapseSubtype Stage

Radiological findings :

Immunohistochemistry study report :

ER, PR, Her2 neu status :

Earlier genomic tests /Targeted Therapies/ (Please mention the results)
.....
.....

Please attach the below reports to the TRF : (if Available)

Attachments :

 Copy of recent pathology /cytology reports including (if available) Test results from all other Molecular Diagnostic Assays by FISH, IHC, or other genetic assays, e.g.,ER, PR, HER2, EGFR, KRAS,etc.

TEST SELECTION

(Sample Type)

- OncoCEPT Solid** (*FFPE block containing tumor tissue) **OncoCEPT Liquid** (*10ml Whole blood EDTA in streck tube)
OncoCEPT Comprehensive (*FFPE block containing tumor tissue) **MSI** (*FFPE blocks with slides + EDTA blood)
ColoComprehensive (MSI+BRAF+KRAS+NRAS) (*FFPE block containing tumor tissue) **MMR by IHC**
PDL-1 test **PDL1 SP142** **PDL1 SP 263** **PDL1 22C3 DAKO** (#Drug details)
OncoCEPT Solid + PDL1 **OncoCEPT Solid Comprehensive + PDL1**
BRCA1 & BRCA2 gene sequencing **Inherited cancer panel**
Other test : Description of test & sample type

In case of inadequate tissue, please tick the test which test would you like us to do first:

OncoCEPT Solid OncoCEPT Solid Comprehensive PDL-1

Drug details for PDL-1 IHC

(PDL-1 IHC indicated in patients with specific tumor type in order to predict their responses to treatment with PDL-1 inhibitors. The specific PDL-1 clone scoring method and eligibility requirements are dependent on the tumor type, stage of malignancy, previous treatment outcomes and specific PDL-1 inhibitors being considered)

Tick	Clone	Drug
<input type="checkbox"/>	Sp263	Nivolumab (opdivo)
<input type="checkbox"/>	Sp263	Durvalumab (imfinzi)
<input type="checkbox"/>	Sp142	Atezolilumab (Tecentriq)
<input type="checkbox"/>	Sp142	Atezolilumab (Tecentriq)
<input type="checkbox"/>	Sp142	Atezolilumab (Tecentriq) Plus nab- paclitaxel (Abaxane)
<input type="checkbox"/>	22C3 DAKO	Pembrolizumab (Keytruda)

SAMPLE DETAILS

Date of Collection (MM/DD/YYYY) Specimen ID

- FFPE of tumour tissue (BIOPSY fixed in 10% Neutral buffered formalin)
 Specimen Site
 No. of paraffin blocks and details:
 Please mention block number on which test has to be performed
 Body Fluid (At least 1 litre) or cell block
 FFPE BLOCK of tumor tissue (BIOPSY fixed in 10% Neutral buffered formalin) with HE stained slide
 Specimen Site
 Unstained poly L lysine coated slides

Cold ischaemia time - mins or hrs or unknown (As time of transfer of tissue after removal from body upto immersion into the 10% neutral buffered formalin)

Time Formalin fixation (10% neutral buffered formalin): known: hours / unknown

(Note : Neuberg Center for Genomic Medicine (NCGM) chooses the best block(s) based on initial morphologic assessment for further IHC PDL-1 study . It makes all efforts are made to preserve and make sure not to exhaust the tissue entirely under study. However in small thin/tiny specimen, there is a possibility of exhausting the tissue to ensure quality and reliability of the results.)

(CAP/ASCO recommendation: for breast markers and GI Her2neu, the cold ischemic time should be < 01 hours and optimal fixation for ER/PgR/Her2Neu in 10% buffered formalin MUST be 06 to 72 hours)

Family History of any Cancer

Sr. No.	Type of Cancer	Age of diagnosis	Relationship with patient	Mother's or father's side	Histopathology / genetic test reports (if available)

Billing Information

Self pay in cash (reference) _____

 Electronic payment (reference) _____



CONSENT/ASSENT FORM

PHYSICIAN CONSENT

I certify that I am patient's treating physician and I consent that this test will aid in patient's ongoing treatment. I have explained the patient about nature and purpose of testing. Patient has given his consent to me for Neuberg Center of Genomic Medicine to

- (1) Perform tests mentioned here.
- (2) Retain the test results.
- (3) De-identify the test report/ result for future research purpose and publication.

I authorize Neuberg Center of Genomic Medicine to perform most appropriate test based on submitted histopathology report.

Signature

Printed Name

Date: DD/MM/YY

PATIENT CONSENT

I certify that I have been explained by my physician that this test will aid in my ongoing treatment/management. I have been explained about nature and purpose of testing. I give my consent to Neuberg Center of Genomic Medicine to

- (1) Perform tests mentioned here.
- (2) Retain the test results.
- (3) De-identify the test report/ result for future research purpose and publication.

I authorize Neuberg Center of Genomic Medicine to perform most appropriate test based on submitted histopathology report.

Signature

Printed Name

Date: DD/MM/YY

Neuberg Centre for Genomic Medicine (NCGM)