Austin HEALTH | Pathology

MOLECULAR HAEMATOLOGY TEST REQUEST FORM

RCPA The Royal College of Pathologists of Australasia — NATA

LABORATORY NUMBER 2741

PATIENT INFORMATION

Surname:	Sex: M / F
First Name:	DOB:
Address:	
Medicare Number:	
Private Health Fund:	Health Fund Number:

Clinical Notes: *(Attach a copy of the relevant Pathology Report)*

SAMPLE TYPE: ❑ Bone Marrow ❑ Blood ❑ Other ______

REQUESTING CLINICIAN / PATHOLOGIST

Name:	
Address:	
Provider No:	
Tel:	Fax:

Referrer Signature: ____________________ Date:__________

Note that you are also accepting full responsibility for this pathology request.

Report Copy (Print CLEARLY): Dr ____________________

Address ____

____

Tel ___________________ Fax___________________

SELECT TEST(S)

❑ **Full Myeloid NGS Panel (39 genes)** *(Note: FLT3 ITD is reported using fragment analysis)*

Gene List - ASXL1, BRAF, CALR, CBL, CEBPA, CSF3R, CXCR4, DDX41, DNMT3A, ETNK1, EZH2, FBXW7, FLT3*, GATA1, GATA2, IDH1, IDH2, JAK2, KIT, KRAS, MPL, MYD88, NOTCH1, NPM1, NRAS, PPM1D, PTEN, RHOA, RUNX1, SETBP1, SF3B1, SRSF2, STAT3, STAT5B, STAT6, TET2, TP53, U2AF1, WT1

❑ **MPN NGS Panel (9 genes) Gene List** - ASXL1, CALR, CSF3R, JAK2, KIT, MPL, SETBP1, SF3B1, SRSF2

❑ **T-ALL Panel (5 genes) Gene List** – FBXW7, KRAS, NRAS, NOTCH1, PTEN

❑ **Single Gene in Myeloid NGS Panel** *(please circle in Gene List above)*

❑ **FLT3 and NPM1 Mutation** ❑ **JAK2 exon 14 analysis**

❑ **BCR-ABL1 testing**

❑ **IGH gene rearrangement** ❑ **IGH Next generation sequencing for MRD monitoring**

SELECT PAYMENT OPTION

❑ **Bill Medicare** *(Patient must sign. Non-rebatable components will be billed to the pathology provider unless otherwise specified)*

If a test is being requested through Medicare the patient's hospital status at the time of the service or when the specimen was collected is required:

- ❑ Private Patient in a private hospital or approved day hospital
- ❑ Private Patient in a recognised hospital
- ❑ Public Patient in a recognised hospital
- ❑ Outpatient in a recognised hospital

Patient's Signature: ______________________Date:__________

Medicare Assignment Form (Section 20A of the HIA 1973)

I offer to assign my right to benefits to the approved practitioner who will render the requested pathology service(s) and any eligible pathological determinable service(s) established necessary by the practitioner.

❑ **Bill Hospital/Pathology Provider** Direct

❑ **Bill Patient** Direct *(Must sign declaration overleaf)* ❑ **Other:** ________________________________

PROVIDE THE FOLLOWING:

- This completed form
- Appropriate sample (Please see page 2 of this form)
- Copy of the Pathology Test Report

SEND TO:

Austin Pathology – Central Specimen Reception

Austin Health; Level 6 HSB

145 Studley Road, Heidelberg, VIC 3084

Fax: (03) 9459 1674 Tel: (03) 9496 3100

Your doctor recommended that you use Austin Pathology. You are free to choose your own pathology provider.
However, if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service.
You should discuss this with your doctor.

Privacy Note: The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update enrolment records. Its collection is authorised by provision of the *Health Insurance Act 1973*. The information may be disclosed to the Department of Health and Ageing or to a person in the medical practice associated with this claim, or as authorised/required by law.

SAMPLE REQUIREMENTS:

- **Myeloid NGS/MPN NGS/T-ALL or Single Gene in Myeloid Panel:**
  9ml peripheral blood (EDTA) OR
  2-4ml of bone marrow (EDTA) OR
  DNA (minimum 20ul at 50ng/ul)

- **BCR-ABL1 testing:**
  For diagnostic samples (p210 and/or p190) by Qiagen real-time PCR assay
  9ml peripheral blood (EDTA) OR
  2-4ml of bone marrow (EDTA)

- **IGH gene rearrangement testing:**
  9ml peripheral blood (EDTA) OR
  2-4ml of bone marrow (EDTA) OR
  Tissue fresh/frozen preferred or FFPE block/slides
  DNA (minimum 20ul at 50ng/ul)

- **IGH gene rearrangement for MRD monitoring**
  Diagnostic sample must be previously tested or provided
  2-4ml bone marrow (EDTA) OR
  DNA (minimum 50ul at 100ng/ul)

- **FLT3 and NPM1 or JAK2 Exon 14 testing:**
  9ml peripheral blood (EDTA) OR
  2-4ml of bone marrow (EDTA)

- **BCR-ABL1 testing:**
  For p210 monitoring by Xpert® Ultra BCR-ABL1 assay
  9ml peripheral blood (EDTA)

BILL PATIENT DIRECT DECLARATION: Billing of Non-Medicare Rebatable Tests

The pathology request that you have been given by your medical practitioner includes tests that could be either partially or not covered by Medicare.

If required, the full cost of testing must be covered by the patient or, in the case of children, their family. Austin Pathology requires your consent to proceed with this testing with the full understanding that you will accept responsibility for payment.

Patient Name: ______________________________________

Test Name(s) : ____

The cost of the test requested by your doctor is estimated at A$ _______________________________

I hereby agree to accept responsibility for full payment or part payment of non-Medicare rebatable tests performed by Austin Pathology.

Patient/ Parent Signature _____________________________________

Date ___/___/___
For further information, please Austin Pathology on 9496 3100.