

**Patient Details**

Given Name: ..... Surname: .....  
 Date of Birth: ..... Gender:  MALE  FEMALE  
 Address: .....  
 Suburb: ..... State: ..... Post Code: .....  
 Phone: ..... Medicare Number: .....  
 Hospital Name: .....  
 Signature: **X** ..... Date: .....

**Clinical Information**

Is this a new diagnosis?  Yes  No  
 Has the patient been treated with systemic anti-tumour therapy?  Yes  No  
 Previous somatic mutation detected (if known): .....  
 Patient Stage: .....  
 Tumour Type:  Colorectal carcinoma  
 Non-small cell lung cancer  
 Melanoma

**Test Required**

| Gene Target   | Tick if Required         |
|---|--------------------------|
| Colorectal Panel - RAS, PIK3CA, BRAF (EGFR)         | <input type="checkbox"/> |
| Lung Panel - KRAS, PIK3CA, BRAF, EGFR (incl. T790M) | <input type="checkbox"/> |
| Melanoma Panel - NRAS, BRAF                         | <input type="checkbox"/> |

**Clinical Details**

**Patient Informed Consent**

My signature on this form indicates that I understand the informed consent and give permission to Australian Clinical Labs to perform the laboratory Aspect Liquid Biopsy tests selected. I have had the opportunity to ask questions and discuss the capabilities and limitations with my healthcare provider. I have been informed that there is no Medicare Rebate for this test and agree to pay the out-of-pocket fee.

This test has a fee of \$550 (per panel).

Please tick one:  Invoice  Pay over the phone (receipt.....)

Patient Signature: **X** ..... Date: .....

In some infrequent cases, it will not be possible to generate an Aspect Liquid Biopsy result. Should this occur you may choose to provide a new blood sample for testing. No additional fees will be incurred for the second test. In the event that you decide not to submit an additional sample for testing, Australian Clinical Labs will refund the full test fee paid. Results will be made available to you through your nominated doctor.

**Referring Clinician Details**

Requesting Doctor: .....  
 Provider Number: ..... Phone: ..... Fax: .....  
 Address: .....  
 Suburb: ..... State: ..... Post Code: .....  
 Referring Clinician Signature: **X** ..... Date: .....

**Copy Doctor Details**

Name: .....  
 Address: .....  
 Suburb: ..... State: ..... Post Code: .....  
 Phone: ..... Fax: .....  
 Copy Hospital: .....

**Instructions For Collectors**

- 1 Please complete patient details, clinical information, patient informed consent and clinician details in FULL
- 2 Collect Two Tubes of Whole Blood into Roche, Cell Free DNA tubes (White cap: Used also for Harmony) – Mix well & gently
- 3 Transport at Ambient Room temperature – Do not centrifuge



**Collection Centres**

For a current list of centres, please visit our website [www.clinicallabs.com.au](http://www.clinicallabs.com.au) or contact us on **1300 453 688** (VIC, NSW, SA & NT) or on **1300 367 674** (WA only). All of our collection centres across Victoria, New South Wales and Western Australia collect for Aspect Liquid Biopsy. Collection centres in South Australia and Northern Territory require appointments for the Aspect Liquid Biopsy Test. Please contact us to find your nearest collection centre and book an appointment.