

# Breast Cancer Recurrence Test



**Laboratory:** Myriad GmbH  
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AFFIX ONE BAR CODE LABEL HERE

- ✔ To avoid delays please complete entire form
- ✔ Please print all information in BLOCK LETTERS

## TEST REQUEST FORM

### PATIENT

Date of Birth (DD-MMM-YYYY): <input type="text"/>	
Gender: Female	Patient ID:
Last Name:	
First Name:	

### BILLING INFORMATION

Payor ID: _____
or
Research #: _____
or
Voucher #: _____

### ORDERING PHYSICIAN

Last Name:	Degree:
First Name:	Clinical ID:
Institution:	
Street, Nr:	
City, Postal Code:	Day Phone:
Country:	Fax:
In addition to receiving the result by mail, by providing my email address, I agree to receive the result electronically.	
E-mail: _____	

### AUTHORIZED SIGNATURE (Physician/Healthcare Provider)

I hereby authorize testing and confirm that informed consent has been obtained from the patient for tissue to be sent to Myriad for analysis. I confirm that this test is medically necessary and results will be used in the medical management and treatment decisions for the patient. I hereby attest that the person listed in the Ordering Physician space above is authorized by law in the relevant jurisdiction to order the test requested herein.

Ordering Physician / Healthcare Provider's Signature

Date (DD-MMM-YYYY)

INTERNAL USE ONLY: Results to Myriad GmbH, # 116309

### PATIENT AUTHORIZATION (Required only for release of results to a third party)

In addition to my consulting physician(s), I authorize the results of my testing be released, if requested, to:

Name

E-mail

Patient's signature

Date (DD-MMM-YYYY)

Forward This Test Request Form To The Laboratory Where The Tumor Specimen Is Located

### CLINICAL/PATHOLOGICAL INFORMATION TO DETERMINE THE EPCLIN RISK SCORE Please provide the following parameters:

Based on EndoPredict validation, accepted samples for the test are: ER+, HER2-, primary, invasive female breast tumors from patients who have not received systemic endocrine therapy and/or chemotherapy.

Breast Cancer: Age at Dx: \_\_\_\_\_

Date of biopsy/surgery (DD-MMM-YYYY):

Tumor Size: ☐ pT1a ☐ pT1b ☐ pT1c ☐ pT2 ☐ pT3 (only invasive area)

ER: ☐ negative ☐ positive

HER2 Status: ☐ negative ☐ positive

Lymph node status (number of positive lymph nodes based on pathological assessment): ☐ 0 ☐ micrometastasis ☐ 1-3 ☐ 4-10 ☐ >10

### SPECIMEN INFORMATION: TO BE COMPLETED BY PATHOLOGIST (Complete instructions are in the Instructions For Use (IFU) sheet).

Paraffin Block with at least 30% of Tumor Tissue:

For a specimen collection set please contact testkit@myriadgenetics.eu

Specimen Type: <input type="checkbox"/> Slides <input type="checkbox"/> Blocks	Tissue/Tumor Type: <input type="checkbox"/> Post Surgical <input type="checkbox"/> Biopsy	Sample Fixative: <input type="checkbox"/> 10% neutral buffered formalin	Other: _____
<input type="checkbox"/> Tissue Block enclosed	Number of Blocks _____	ID* _____	<input type="checkbox"/> H&E slide (2-5 microns thickness)
<input type="checkbox"/> Tissue Slides enclosed (10 microns thickness)	Number of Slides _____ (minimum of 5 slides)	ID* _____	<input type="checkbox"/> H&E slide (2-5 microns thickness)

PLEASE NOTE: A COPY OF THE PATHOLOGY REPORT MUST BE SUBMITTED WITH SPECIMEN

\*Specimen Identification Number as it appears on the tissue blocks or slides submitted to Myriad.

### AUTHORIZED SIGNATURE (Pathologist or Authorized Representative)

I hereby declare that the clinical information described above on this Test Request Form is correct and the tissue belongs to the patient mentioned above.

Pathologist or Authorized Representative Name (in PRINTED LETTERS)

Signature

Date (DD-MMM-YYYY)

INTERNAL USE ONLY: Bill Institution BIE \_\_\_\_\_.

### TISSUE RETURN

I request the remaining tissue to be returned. ☐ Yes ☐ No

Name: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail / Phone: \_\_\_\_\_

For information or questions regarding Myriad's privacy policy, please visit our website: <http://www.myriadgenetics.eu>