RPAH Neuropathology
METHYLATION PROFILING REQUEST FORM

PATIENT DETAILS

Surname: .....

Given name: .....

Date of birth: ..... **Gender:** ☐ F / ☐ M

Address: .....

.....

Referring lab ID: .....

Medicare card number:

										-	

Relevant clinical notes:

PLEASE APPEND HISTOPATHOLOGY REPORT

REQUESTING DOCTOR DETAILS

Name: .....

Address: .....

.....

Phone: ..... **Fax:** .....

Email: .....

Provider number:

Signature: ..... **Date:** .....

Copy to:

TEST REQUESTED

✓ **Methylation Profiling ($1000)**

Classification using methylation profiling is a research tool under development, it is not verified and has not been clinically validated. Implementation of the results in a clinical setting is in the sole responsibility of the treating physician.

Technique: Illumina EPIC Human Methylation microarray

Turnaround time: 6-8 weeks

PAYMENT

BILL SERVICE CHARGE TO:

☐ Patient (financial consent required)

☐ Referring laboratory / department:

The department forwarding the request will be billed by RPAH unless the 'Patient Financial Consent' is signed below or otherwise indicated.

SPECIMEN REQUIREMENTS

All specimens must be labelled with at least TWO patient identifiers and be accompanied by a COPY of the original histopathology report

For Methylation Profiling	1 x FFPE tissue block with **at least 80%** tumour cellularity

Residual samples may be used for test development or quality control purposes. The tissue block will be returned after test completion.

PLEASE SEND SPECIMEN(S) AT AMBIENT TEMPERATURE TO:

Molecular Neuropathology
Room 727, Level 7
Brain & Mind Centre - Building F (M02F)
94 Mallett Street
Camperdown NSW 2050

Tel: (02) 9351 0741 Fax: (02) 9114 4020
Email: neuropathology.lab@sydney.edu.au

PATIENT FINANCIAL CONSENT

FOR PAYMENT OF NON-REBATABLE TEST(S) – I understand that my treating practitioner has requested a test that is not covered by Medicare and may not be covered by a Health Fund. I understand that I will receive an invoice from the Department of Neuropathology, Royal Prince Alfred Hospital. I agree to accept responsibility for the full payment of the fees for the test.

Patient's signature: ..... **Date:** .....

PRACTITIONER'S USE ONLY:
(Reason patient cannot sign) .....

☐ **Verbal consent was provided by patient**

(Laboratory Use Only)

SPECIMEN RECEIVED: (*Date*) (*Time*) (*Received by*)

☐ x FFPE block(s) Label: .....

Other specimens: .....

SERVICE REQUESTED:

Methylation Profiling

SERVICE CHARGED:	Total service charge:	**$ 1000**	Bill to: ☐ Intrahealth ☐ Patient ☐ External	Invoice requested: