CAMBRIDGE CLINICAL LABORATORIES

Oncology Companion Diagnostics
Test Request Form

Select the Test(s) required (please tick and advise funding if applicable)

	Test required	Funded by
☐	**EGFR**	
☐	**BRAF**	
☐	**ALK FISH**	
☐	**ROS1 FISH**	
☐	**HER2 FISH**	
☐	**KRAS G12C (NSCLC)**	
☐	**RAS-RAF (NGS)**	
☐	**PIK3CA**	

Instructions for Requesting Physicians / Pathologists:

1. Please fully complete sections A and B. Missing compulsory information may result in test delay.
2. If you wish for a sample collection kit to be dispatched to the sample retention centre, Please complete section C and send the whole form to **Email**: info@CamClinLabs.co.uk
3. Return the Test Request Form with the sample.
4. Please ensure you provide details on the funding of required tests.

Tumour type: (required for interpretation)

☐	**PD-L1 22C3**		**NSCLC** ☐ **HNSCC** ☐	**Urothelial** ☐ **Gastric Cancer** ☐ **Cervical** ☐	
☐	**PD-L1 SP142**		**NSCLC** ☐	**Urothelial** ☐ **Breast Cancer** ☐	
☐	**RET Fusions (NGS)**		**NSCLC** ☐	**PTC** ☐	
☐	**RET Mutations (NGS)**		**MTC** ☐		

If a test is not funded by a pharmaceutical company or on an existing site account, please contact Cambridge Clinical Laboratories to provide payment details. If these details are not provided then an invoice may be sent to the requesting site or physician.

A. Patient Information

Please note the fields marked * are compulsory

Please fill out completely and include at least 3 unique patient identifiers or affix label

*Patient's First Name: ..... *Patient's Last Name: .....

*DOB: ..... (DD/MM/YYYY) *Patient Gender (M/F) .....

*Patient ID (MRN/NHS No): ..... *Specimen Type: .....

Pathology Report No: ..... *Date Sample Taken: ..... (DD/MM/YYYY)

*Estimated percentage of tumour material in the tissue sections submitted: .....%

Affix Patient Label Here

B. Requesting Physician / Pathologist Information

*Physician / Pathologist Name: ..... *Clinic/Hospital: .....

Address: .....

..... Postcode: .....

Tel: ..... Fax: ..... Email: .....

Results will be reported to email address provided unless an alternative method is advised.
I hereby authorise a tumour sample of the above patient to be tested for genes as selected here

*Authorised Signature: ..... *Date: ..... (DD/MM/YYYY)

C. Sample Retention Centre/Pathologist (if different to section B)

Pathologist Name: ..... *Clinic/Hospital: .....

Address: .....

..... Postcode: .....

Tel: ..... Fax: ..... Email: .....

For the Pathologist:

If using a Sample Collection Kit, please:-

- Prepare a tumour sample according to the instructions provided, then **complete the identifier labels with at least 3 unique identifiers (i.e. first name, last name and date of birth) and attach to the primary sample containers (i.e. the sample tubes or slides)**
- Finally return the signed form with the tumour sample to Cambridge Clinical Laboratories.

CCL USE ONLY CCL ID No ..... Date..... Entered by..... Validated by.....

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