General Referral Form

IGENZ Innovative genomics

Patient Information

Surname: First name:

NHI: Sex at birth (*please circle*): M / F

DOB:

Sample Details and Clinical Information

Specimen type (*please circle*): FFPE / blood / bone marrow / trephine / other:

Origin of tissue: Date and time collected:

Referring laboratory reference:

Supporting clinical information:

Please attach pathology report

Test/s Requested

Molecular Oncology: (*min. 12 slides*)

MassARRAY mutation testing:

- ☐ Colon
- ☐ GIST
- ☐ Lung
- ☐ Gynae
- ☐ Melanoma
- ☐ IDH 1/2
- ☐ MLH1 Methylation
- ☐ Other (*please state*) _____

☐ CGH Array (Microarray)

FISH: (*min. 2 slides/probe*)

Probe/s:_____

_____

Reporting Information

Referring Dr: NZMC#:

Contact #: Email:

Signature: Date:

Copy to Dr: Email:

Billing Information

Please indicate method of payment: (Invoice will be emailed to the referring doctor if this section is blank)

☐ Invoice Health NZ:_____Purchase Order # (required) _____

☐ Invoice Private Clinic:_____Billing contact: _____

☐ Private patient to pay directly (*please attach IGENZ Consent and Payment Form*)

Supplementary Information (eg tumour content)

Please refer to our website for specific sample requirements: www.igenz.co.nz

ACCREDITED IANZ TESTING LABORATORY № 987

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