GENOSTICS® AUSTRALIA PTY LTD

Maintrac® CTC
Test Request Form - AUSTRALIA & NEW ZEALAND

1. PATIENT DETAILS: PLEASE COMPLETE SECTIONS 1, 9, 10 in order to proceed with a test

TITLE	SURNAME	FIRST NAME	D.O.B. *(dd/mm/yyyy)* / /	M F

STREET ADDRESS	SUBURB & STATE	COUNTRY	POSTCODE

PHONE (+area code)	MOBILE	EMAIL

2. REQUESTING PRACTITIONER: PLEASE COMPLETE SECTIONS 2, 3, 4

FULL NAME	TYPE OF PRACTITIONER

PROVIDER NUMBER	EMAIL (**TEST RESULTS WILL BE EMAILED TO THIS EMAIL ADDRESS)

PHONE (+area code)	MOBILE	FAX

PRACTICE NAME

PRACTICE - STREET ADDRESS	SUBURB	COUNTRY	POSTCODE

PRACTITIONER SIGNATURE: ____________________ **DATE:** *(dd/mm/yy)* ____/____/_____

3. DIAGNOSIS / TREATMENT/ HISTORY

Type of cancer and histology: ______________________________ Date of initial diagnosis: _____/ _____ / ______

Stage of initial diagnosis: __________________Current diagnosis:__________________

FOR DETAILED MEDICAL HISTORY, PLEASE COMPLETE THE ATTACHED MEDICAL QUESTIONNAIRE

4.MAINTRAC TESTS: Please clearly mark the required test/s with an ✗ in the relevant boxes of Sections A and B

A. **CTC COUNT** *Treatment monitoring*: intended for baseline count and follow-up monitoring ……….................................... AUD $ 690.00

PLEASE SELECT THE APPLICABLE SHIPPING COSTS FOR AUSTRALIA OR NEW ZEALAND AT THE BOTTOM OF PAGE 1

B. ADDITIONAL TESTS: The following tests must be done in conjunction with a CTC Count test. The costs are in addition to the CTC Count test.

i. COMPANION DIAGNOSTICS: *Biomarker Test for Targets*

Androgen Receptor .... AUD $ 490.00

Estrogen Receptor .... AUD $ 490.00

EGFR Receptor .... AUD $ 490.00

EGFR amplification (FISH) .... AUD $ 580.00

HER2/neu (FISH) .... AUD $ 580.00

Ki-67 .... AUD $ 490.00

MEL- A .... AUD $490.00

Progesterone Receptor .... AUD $ 490.00

PLAPR (Sarcoma specific) .... AUD $ 490.00

PD-L1... AUD $ 490.00

P53 .... AUD $ 490.00

PSA .... or PSMA.......... AUD $ 490.00

Others on request (please contact Genostics to discuss availability & price): ________________________ AUD $ __________

ii. TUMOUR SPHERE UNITS: *Cluster Formation Test:* up to 21 days growth in nutrient media for cancer stem cells ....AUD $ 1,200.00

iii. CUSTOMISED CHEMOSENSITIVITY: *Test for Treatments* (please print substance name/s clearly)

1 x Sub.....AUD $ 620.00

2 x Sub.....AUD $ 1240.00

3 x Sub.... AUD $ 1790.00

4 x Sub.....AUD $ 2415.00

5 x Sub.....AUD $ 3035.00

6 x Sub.....AUD $ 3585.00

iiii. Substances in Combination (2 or 3 substances tested in combination for synergistic effect) ($750.00/combination)

(1) (2) (3) AUD $ 750.00

(1) (2) (3) AUD $ 750.00

C. SHIPMENT COSTS - *Australia and New Zealand*

SHIPMENT COSTS AUSTRALIA ....AUD $ 155.00

SHIPMENT COSTS CBD NEW ZEALAND...........AUD $290.00 **SHIPMENT COSTS REGIONAL NEW ZEALAND**............AUD $ 320.00

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING THIS FORM:
Please complete BOTH PAGES of this request form and fax to +61 2 8088 7097 or email admin@genostics.com.au. A kit will be sent to the patient's address (unless otherwise advised) once a completed form has been received and full payment has been processed. Visit www.genostics.com.au/tests for more blood collection and shipping instructions.

FOR PATIENTS RESIDING IN THE CAPITAL CITIES OF AUSTRALIA AND NEW ZEALAND

- Blood collection and courier **PICK-UP** or **DROP-OFF** must take place on a MONDAY ONLY
- Book the courier in the morning on the day of blood collection – MONDAY ONLY

FOR ALL OTHER PATIENTS:

- Blood collection and courier **DROP-OFF** must take place on a MONDAY ONLY
- Please note the courier depot nearest you as well as the cut-off time for kit drop-off; this information is provided in the Test Collection Instructions contained in the kit or by visiting www.genostics.com.au/tests/#orderatest

PRIVACY AND CONFIDENTIALITY

Genostics complies with all the applicable privacy laws and is committed to taking all reasonably available measures to protect your privacy and the confidentiality of the information you provide on this test request form.

5. TERMS AND CONDITIONS:

Please ensure that you have discussed the following with your Health Practitioner before proceeding with a test request:

i) your medical condition in relation to the test/s you are requesting;
ii) an explanation of the test/s requested on this test request form;
iii) the purpose and benefit of the test/s requested on this test request form.

You confirm that you have had adequate time to fully understand the nature of the test/s chosen, the associated costs, and the terms as set out on this test request form.

You confirm that you are of sound mind and over 18 years of age – if the person undertaking the test/s requested on this test request form is a minor, then consent must be provided by a parent or legal guardian.

6. CANCELLATION POLICY:

The following cancellation/administration fees apply once payment/a test request form has been received or processed:

i) Cancellation within 3 months from date payment is processed and/or a kit issued and prior to blood collection will incur a cancellation fee of AUD$130.00 per test request form;
ii) There will be no refund for cancellation after 3 months from the date payment is processed and/or a kit issued;
iii) Additional fees may apply should Genostics be required to re-issue documents and/or kit contents after 3 months from date payment is processed and/or kit issued;
iv) There will be no refund for cancellation from and after blood collection and/or shipment of sample to the laboratory. Genostics is not liable for, nor will Genostics issue refunds for: sample damage or loss caused by failure to package and ship the sample according to the Test Collection Instructions supplied in the kit; should re-collection be required a fee of AUD $130.00 will be charged;

7. DISCLAIMER/LIABILITY EXCLUSION:

The tests (described in this form) facilitated by Genostics do not replace currently recommended methods of cancer detection and screening. Test results do not constitute a diagnosis of disease or condition. The tests and results do not offer conclusive and consistent solutions to cancer diagnoses and treatment. CTCs (Circulating Tumor Cells) propagate and respond uniquely to treatment and may test uniquely. Each individual is unique. Test results can only aid diagnosis, detection, monitoring and cancer treatment decisions (including targeted therapy), within the context of clinical assessment and standard screening tests.

Do not use the content of this document, test results or related information to dispense with or disregard any medical advice, nor to delay seeking medical advice. A patient should always consult his/her health/medical practitioner to determine the appropriateness of test/s for his/her case or if he/she has any questions regarding a medical condition or treatment plan. The interpretation of any test and clinical management of the relevant patient's condition is the responsibility of the treating health/medical practitioner.

This document and its content do not create a health/medical practitioner-patient relationship. Genostics does not offer any medical advice. Genostics does not engage in medical practice.

Genostics gives no and can give no warranties or guarantees (express or implied, statutory or otherwise) concerning the test/s, whether as regards (1) procedures or quality, (2) technical, functional and other specifications, (3) test results, or (4) information or advice obtained pursuant to this document or test results.

8. CONSENT: By signing this request form, I the person undertaking the test/s, or the parent/legal guardian:

i) Give my consent to Genostics to facilitate the test/s & services requested on this test request form, the electronic release and delivery of test results, and the collection of my personal data for research purposes;
ii) Give my consent to Labor Pachmann to use my blood sample for medical testing and analysis, as per this request form, the electronic release and delivery of test results, and I relinquish any claim of ownership of the blood sample or any of its components;
iii) Give my consent to Labor Pachmann & Genostics Australia to use my blood sample for medical research development and the collection of data for statistical analysis;

I also confirm that I understand, consent and agree to all terms in or referenced in this test request including the cancellation policy, data use and privacy terms, price and payment terms and the disclaimer and liability exclusions.

9. PATIENT SIGNATURE:________________________ DATE *(dd/mm/yy)* :___/___/___

REMINDER - Have you selected the applicable shipping costs for Australia or New Zealand?

10. PAYMENT SECTION: METHOD OF PAYMENT: VISA OR MASTERCARD ONLY

PLEASE PLACE THE TOTAL COST OF THE TEST/S REQUESTED IN THE 'AMOUNT' SECTION BELOW

VISA MC	CARD NUMBER: ____________________________________	EXPIRY DATE ON THE CARD: *(mm/yyyy)* ______/__________
CARDHOLDER'S NAME *(as it appears on the card)*: ____________________________	CARDHOLDER'S SIGNATURE: ____________________________	AMOUNT: AUD$__________•00

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Medical Questionnaire for research and studies

Laborpraxis Dr. Pachmann

DAkkS Deutsche Akkreditierungsstelle D-ML-13345-01-00

GENOSTICS Individualised diagnosis & therapies based on molecular medicine

*This Questionnaire to be completed by the treating **practitioner** + **patient** and submitted together with the Request Form for testing. The data obtained may be collected and utilised for research and studies.*

Patient's and Doctor's data

Patient:		**Attending Physician:**
Date of birth:	Sex: ◯ Male ◯ Female	Doctor's office:
First name:		Name:
Name:		Address:
Address:		
		Phone:
Phone:		Email:
Email:		

Primary diagnosis

Primary diagnosis	◯ Carcinoma ◯ Sarcoma ◯ Melanoma ◯ Others:______________	**Grade**	**Date of 1st Diagnosis**
y◯ c◯	pT____ pN____ M____ R____ ER____ PR____ HER2/neu____ sLN____		

Treatment for Primary lesion

Treatment	**Name of medicines**	**Dates**
NeoAdjuvant		
Adjuvant		
Targeted, Immune Therapies		

Treatment	**Results**	**Dates**
NeoAdjuvant Radiotherapy		
Surgery		
Radiotherapy		

Result of primary treatment R0

◯ partial remission ◯ complete remission ◯ stable ◯ progression

Maintenance Therapy *(following primary diagnosis and treatment)*

Name of medicines	**Dates**

Recurrence of Metastases

Location:	**Dates**
◯ local ◯ bones ◯ organs:________________ ◯ tissues ◯ other: ________________	
◯ local ◯ bones ◯ organs:________________ ◯ tissues ◯ other: ________________	
◯ local ◯ bones ◯ organs:________________ ◯ tissues ◯ other: ________________	
◯ local ◯ bones ◯ organs:________________ ◯ tissues ◯ other: ________________	
◯ local ◯ bones ◯ organs:________________ ◯ tissues ◯ other: ________________	

Primary diagnosis | Treatment for Primary lesion | Result R0 | Maintenance Therapy | Maintenance Therapy

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This Questionnaire to be completed by the treating ***practitioner*** *+* ***patient*** *and submitted together with the Request Form for testing. The data obtained may be collected and utilised for research and studies.*

Patient Data

Patient Name:	*Sex:* *Male* *Female*
Date of Birth:	

Please repead

Treatment of Metastases

Treatment	***Name of medicines***	***Dates***
Surgery		
Radiotherapy		
Chemotherapy		
Targeted Treatments		
Immunotherapy		
Complementary Medicine		

Treatment of Metastases

Current stage of disease

○ *M0* ○ *M1* ○ *local* ○ *distant*

Current stage

Planned Therapies

Name	***Dates***

Planned Therapies

Performance Status (ECOG)

○ *0* ○ *1* ○ *2* ○ *3* ○ *4* ○ *5*

ECOG

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Date, practitioner's signature

Date, patient's signature

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Laborpraxis Dr. Pachmann

ilac-MRA

DAkkS Deutsche Akkreditierungsstelle D-ML-13345-01-00

GENOSTICS Individualised diagnosis & therapies based on molecular medicine

Quality of Life Questionnaire for research and studies

*This Questionnaire to be completed by **the patient** and submitted together with the Request **Form** for testing. The data obtained may be collected and utilised for research and studies.*

Please repead

Patient Data

Patient Name:	*Sex:* *Male* *Female*
Date of Birth:	

Quality of life

Quality of life

Please fill in:	***Not at all***	***A little***	***Quite a bit***	***Very much***
Do you have any trouble doing strenuous activities, like carrying a heavy shopping bag or a suitcase?		○	○	○
Do you have any trouble taking a long walk?	○	○	○	○
Do you have any trouble taking a short walk outside of the house?	○	○	○	○
Do you need to stay in bed or a chair during the day?	○	○	○	○
Do you need help with eating, dressing, washing yourself or using the toilet?	○	○	○	○
During the past week				
Were you limited in doing either your work or other daily activities?	○	○	○	○
Were you limited in pursuing your hobbies or other leisure time activities?	○	○	○	○
Were you short of breath?	○	○	○	○
Have you had pain?	○	○	○	○
Did you need to rest?	○	○	○	○
Have you had trouble sleeping?	○	○	○	○
Have you felt weak?	○	○	○	○
Have you lacked appetite?	○	○	○	○
Have you felt nauseated?	○	○	○	○
Have you vomited?	○	○	○	○
Have you been constipated?	○	○	○	○
Have you had diarrhea?	○	○	○	○
Were you tired?	○	○	○	○
Did pain interfere with your daily activities?	○	○	○	○

For the following questions please mark the number between 1 (very poor) and 7 (excellent) that best applies to you

How would you rate your overall health during the past week?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7

How would you rate your overall quality of life during the past week?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7

Have you had difficulty remembering things?	○	○	○	○
Has your physical condition or medical treatment interfered with your family life?	○	○	○	○
Has your physical condition or medical treatment interfered with your social activities?	○	○	○	○
Has your physical condition or medical treatment caused you financial difficulties?	○	○	○	○

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iii) Give my consent to Labor Pachmann to use my blood sample for medical research development and the collection of data for statistical analysis;
I also confirm that I understand, consent and agree to all terms in or referenced in this test request including the cancellation policy, data use and privacy terms, price data use and privacy terms, price and and payment terms and the disclaimer and liability exclusions.

Date, patient's signature