

SCL Biomarker Consent and Payment Form

(To be accompanied by a referral form)

Patient Information:

Surname:

First Names:

Date of Birth:

NHI:

Address:

Contact number:

E-mail:

Requesting Clinician:

Patient Consent:

I understand that laboratory testing on my tissue sample is part of the investigation for my tumour and the test to be performed has been explained to me by the requesting clinician. I give permission for my tissue sample to have the following test performed and the test result will be sent to the requesting clinician:

PD-L1 (SP263) immunohistochemistry (CPS); other cancer (Test reference code –P1)	\$250.00 (inclusive of GST)
BRAF V600 PCR (Idylla); melanoma (Test reference code –B1)	\$500.00 (inclusive of GST)
KRAS-BRAF-NRAS (Idylla); colorectal cancer (Test reference code –B2)	\$550.00 (inclusive of GST)
HER2 Immunohistochemistry; oesophageal or stomach cancer (Test reference code –H1)	\$200.00 (inclusive of GST)

Patient Signature:

Date:

Payment Details (Samples will be processed when payment is received)

Internet Banking Details (Please use SURNAME, NHI and TEST reference code)

Bank: ANZ
Account: Southern Community Laboratories
Account number: 01 0906 0090006 000

Credit Card Payment: Payment by Credit Card may be made over the phone by calling the Southern Community Laboratories Accounts Department on 03 474 8341.

Total Paid: _____ **Tick if Receipt required**
