

Test Requisition Form

RPPA BREAST ASSAY

Please Fax to **720-302-2400** or Email to **clientservices@igniteproteomics.com**
For Support: 720-935-3916



Patient Contact info: <input type="checkbox"/> CHECK IF DEMOGRAPHIC FACE SHEET IS ATTACHED (if not complete below)							
Last Name:		First Name:		MI:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:	Medical Record #:
Email:			Primary Phone:			Secondary Phone:	
Address:		City:		State:	Postal Code:	Country:	
Patient Insurance info: <input type="checkbox"/> CHECK IF INSURANCE CARD FRONT/BACK IS ATTACHED (if not complete below)							
Primary Insurance Carrier:				Policy #:		Group #:	
Secondary Insurance Carrier:				Policy #		Group #:	
Patient Clinical Context: <input type="checkbox"/> CHECK IF PAST MEDICAL TREATMENT IS ATTACHED (if not complete below)							
Cancer Type: <input type="checkbox"/> HER2+ <input type="checkbox"/> HER2-/HR+ <input type="checkbox"/> TNBC		Histology: <input type="checkbox"/> Ductal <input type="checkbox"/> Lobular <input type="checkbox"/> Inflammatory		Stage:		Metastatic Site(s): <input type="checkbox"/> Lung <input type="checkbox"/> Bone	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:				<input type="checkbox"/> CNS <input type="checkbox"/> Other:	
Current/Last Line of Therapy: <input type="checkbox"/> NED <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> Other:			Current/Last Regimen:				
ER IHC: <input type="checkbox"/> Negative <input type="checkbox"/> Positive (Intensity ___+ Staining ___%)		HER2 IHC: <input type="checkbox"/> Negative <input type="checkbox"/> Positive (Intensity ___+)		PD-L1 IHC: <input type="checkbox"/> Negative <input type="checkbox"/> Positive (CPS/TPS ___%)			
PR IHC: <input type="checkbox"/> Negative <input type="checkbox"/> Positive (Intensity ___+ Staining ___%)		HER2 FISH: <input type="checkbox"/> Negative <input type="checkbox"/> Amplified (Ratio ___)		BRCA1/2: <input type="checkbox"/> Mutated		PIK3CA: <input type="checkbox"/> Mutated	

Ordering Physician Info:							
Physician Name:			NPI#:			Practice Name:	
Address:		City:		State:	Postal Code:	Country:	
Phone #:		Fax #:		Report Delivery Email:			
Office Contact Name:			Office Contact Email:			Affiliated Hospital:	
Additional Physician to be Copied on Report: (i.e., If ordering surgeon, copy treating medical oncologist here)							
Physician Name:		Phone #:		Fax #:		Report Delivery Email:	

Specimen/Pathology Info: <input type="checkbox"/> CHECK IF PATHOLOGY / CYTOLOGY REPORT(S) ARE ATTACHED (if not complete below)							
Pathology Lab Name:			Phone #:		Fax #:		Email:
Address:		City:		State:	Postal Code:	Country:	
Specimen ID-Accession #:		Collection Date:	Collection Site:		Collection Facility:	Hosp Inpatient or Hosp Outpatient: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Patient Discharge Date:	

PHYSICIAN STATEMENT

My signature constitutes a certificate of Medical Necessity and I certify that I am the patient's treating physician and that the Ignite RPPA Breast Assay Report will inform the patient's ongoing treatment plan. I have explained to the patient the nature and purpose of the use of the patient specimen, the testing to be performed, and the use of personal medical history for the RPPA report. I have obtained informed consent, to the extent legally required, to permit Ignite Proteomics to (a) obtain the specimen necessary for testing (b) facilitate the testing, (c) obtain personal medical history for purposes of producing a Ignite Report, (d) retain the specimen, personal medical history, and test results for an indefinite period for internal quality assurance/operations purposes, and (e) de-identify the specimen, personal medical history and test results and use or disclose such de-identified results for future unspecified research or other purposes.

	<hr/> Ordering Physician Signature	<hr/> Date (MM/DD/YYYY)
--	------------------------------------	-------------------------



Ignite Proteomics, LLC | 15000 West 6th Avenue, Suite 400 | Golden, CO 80401
 ph: 720.935.3916 | email: clientservices@igniteproteomics.com | www.igniteproteomics.com