Department of Anatomic Pathology
Parkway Laboratories
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Request for Molecular Pathology Tests

1. Patient Information					
Name (As in NRIC / Passport):					
NRIC / Passport No:			Lab Accession No.:		
Gender:	☐ Male ☐ Female	Ethnicity:	☐ Chinese ☐ Malay ☐ Indian ☐ Others:		
2. Clinical Information					
Clinical Diagnosis:			Stage of Disease:	☐ Localised ☐ Metastatic	

2. Type of Test *(Please tick accordingly)*		**3. Sample Requirement** *(Please tick accordingly)*
☐	Microsatellite Instability (MSI) by RT-PCR (Idylla)	For each test: ☐ Surgical/Biopsy: 3 unstained FFPE (5µm) ☐ Core biopsy: 5 unstained FFPE (5µm)
☐	EGFR Mutational Analysis by RT-PCR (Idylla)	
☐	KRAS Mutational Analysis by RT-PCR (Idylla)	
☐	NRAS+BRAF Mutational Analysis by RT-PCR (Idylla)	
☐	Gene Fusion Assay by Idylla (ALK, ROS1, RET and MET exon 14 skipping)	
☐	KRAS+NRAS+BRAF Mutational Analysis by RT-PCR (Idylla)	☐ Surgical/Biopsy: 6 unstained FFPE (5µm) ☐ Core biopsy: 10 unstained FFPE (5µm)
☐	Others:	

4. Mode of Payment *(Please tick an option)*			
☐	Bill Inpatient	Patient Account No:	
☐	Bill Clinic		
☐	Patient to Pay	☐ MEH ☐ MNH ☐ GEH *(Medical Centre / Annexe Block) ☐ PEH	
5.	**Tumour Cellularity**		

6. Authorization	
Physician Name & Clinic Stamp:	

1. I attest that I am the authorized physician of this patient. I have explained the purpose of the above-mentioned test(s) to the patient, parent, or legal guardian and they have consented to the test being performed. I have provided appropriate financial counselling to the patient, parent, or legal guardian and they are aware of any additional charges.
2. For genetic test(s), I verify that I have provided counselling to the patient under the Ministry of Health guidelines and the Code of Practice for clinical genetics and genomics testing services.

By submitting the form, I represent and warrant that:
1) I have obtained the patient's, parent's or legal guardian's consent for Parkway Laboratory Services Ltd(PLS), its service providers and affiliates to collect, use and disclose the patient's personal data for the purposes of conducting/providing the requested lab tests and other reasonably related purposes outlined in the IHH Healthcare Singapore Data-Protection Notice, accessible at http://www.ihhhealthcare.com/singapore/data-protection-notice.
2) I agree and undertake to indemnify PLS, its service providers, and affiliates against any loss, damage, liabilities, fines, sanctions or penalties they may incur as a result of or in connection with any breach of the representations and warranties provided herein.

Signature of Physician:		Date:
Signature of Patient/ Patient's or Parent's (or Legal Guardian's):		Date:

7. Request Review (*Parkway Laboratories Use Only*)			
☐	SAP		
☐	LIS		
Billing		Staff Initial	Date