Genomic Diagnostics Laboratory,
6th Floor, St Mary's Hospital,
Oxford Road,
Manchester, M13 9WL
Tel: 0161 276 3265 or 0161 701 4919

REQUEST FOR PLASMA EGFR MUTATION TESTING – PROVIDED BY ASTRAZENECA AS A SERVICE TO MEDICINE

PATIENT DETAILS ***(affix a printed label if available)***

Forename(s):

Surname:

DoB: Sex: M/F

H&C No: NHS No:

Address:

Postcode:

REFERRER DETAILS

Consultant:

Date of request:

Address for reporting/invoicing:

Tel: Fax:

Who should the report be sent to?
Email:

Report by: Email ☐ *(registration may be required)*
Fax ☐ *(a 'Safe Haven' fax no is required)*

CLINICAL DETAILS ***(please select/delete as appropriate)***

Confirmed NSCLC? Yes/No

Date and time of blood draw:

dd/mm/yyyy _____ hh:mm _____

Is the patient chemo-naïve?
Yes ☐ No ☐

Smoking status:
Never smoker ☐
Current smoker/Ex smoker ____ pack years

Patient ethnicity: _____

Tumour Histology *(select one)*

Adenocarcinoma ☐ Squamous ☐
Large cell ☐ NOS ☐

Has the patient progressed on their first line TKI?
Yes ☐
No ☐

Primary EGFR Mutation _____

Please give the EGFR mutation name identified in the original diagnostic tissue sample or include a copy of the original report

TNM (if known) _____

ADDITIONAL INFORMATION:

- **Samples must be collected using a stabilisation tube, these can be obtained from the laboratory.**
- **Please send samples to the address at the letterhead above.**
- **Please dispatch samples within 24 hours of collection at ambient temperature. Do not refrigerate the samples.**
- **Please ensure all blood tubes are clearly labelled with the patients name and D.O.B and that all details on this form are complete.**
- **Please ensure that blood collection tubes are filled to the fill line, a minimum of 8mL of blood is needed for optimum mutation detection.**
- **Please invert the tube gently 8-10 times following blood draw.**
- **We do not recommend that blood samples are taken whilst the patient is on chemotherapy.**