# Test Requisition Form
## RPPA for Breast Cancer

Please Fax to **720-302-2400 or** Email to
**clientservices@igniteproteomics.com**
For Support: **888-847-5472**

Ignite Proteomics
MEASURE WHAT MATTERS

| Patient Contact info: ☐ **CHECK IF DEMOGRAPHIC FACE SHEET IS ATTACHED** (if not complete below) | | | | | |
|---|---|---|---|---|---|
| Last Name: | First Name: | MI: | Sex: ☐ M ☐ F | DOB: | Medical Record #: |
| Email: | Primary Phone: | | Secondary Phone: | | |
| Address: | City: | State: | Postal Code: | Country: | |

| Patient Insurance info: ☐ **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: ☐ **CHECK IF PAST MEDICAL TREATMENT IS ATTACHED** (if not complete below) | | | |
|---|---|---|---|
| Cancer Type: ☐ HER2+ ☐ HER2-/HR+ ☐ TNBC ☐ Other: | Histology: ☐ Ductal ☐ Lobular ☐ Inflammatory ☐ Other: | Stage: | Metastatic Site(s): ☐ Lung ☐ Bone ☐ CNS ☐ Other: |
| Current/Last Line of Therapy: ☐ NED ☐ 1st ☐ 2nd ☐ 3rd. ☐ Other: | Current/Last Regimen: | | |
| ER IHC: ☐ Negative ☐ Positive (Intensity ___+ \| Staining _____%) PR IHC: ☐ Negative ☐ Positive (Intensity ___+ \| Staining _____%) | HER2 IHC: ☐ Negative ☐ Positive (Intensity ___+) HER2 FISH: ☐ Negative ☐ Amplified (Ratio _____) | | PD-L1 IHC: ☐ Negative ☐ Positive (CPS/TPS ___%) BRCA1/2: ☐ Mutated PIK3CA: ☐ 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: ☐ **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: ☐ Yes ☐ 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 Theralink 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 assay 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.*

| | |
|---|---|
| _____ Ordering Physician Signature | _____ Date (MM/DD/YYYY) |



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