PLEASE COMPLETE AND PRINT ALL PAGES AND RETURN WITH SPECIMEN

Unit 210-211 Cambridge Science Park,
Milton Road, Cambridge,
CB4 0WA, United Kingdom

+44 (0)1234 567890

info@edxmedical.com

TC100 - Testicular cancer test requisition form

Combined serum microRNA (M371) and classical tumour markers (AFP, β-hCG, LDH)

TREATING ONCOLOGIST INFORMATION		
Last Name	First Name	
Physician Email	Phone No.	
Office/Hospital Name	Department	
City	County	Post Code

PATIENT INFORMATION		
Last Name	First Name	
Patient ID Number	DOB	Biological Sex ☐M ☐F

ORDERING PHYSICIAN *(or other Licensed Medical Professional)*

Medical Professional Consent

My signature on this form constitutes a Certification of Medical Necessity.

- I consent to the Company holding my personal and professional details for the purpose of supporting my work as a physician. I confirm that I am licenced and authorised as a practicing physician to order and interpret **tests** for the patient named on this form.
- I confirm that I have reviewed the patient consents on this form, that I have discussed the test with the patient, and that the patient has given consent for such testing to be performed by the Company and for the results to be reported back to me in order to provide appropriate medical interpretation.
- I authorise the Company to provide the **test** for the patient named on this form, and am authorised to act on behalf of my employer, whose details appear on this form. I understand and accept that the Company is relying on the clinical diagnosis provided by myself on this form in order to provide information about potential therapeutic options based on the **test** results. I accept that an incorrect clinical diagnosis by myself could adversely affect the relevance of the **test** report provided by the Company and it's partners.

You may contact datacontroller@edxmedical.com to request a copy of all your personal information held by the Company and may also request its deletion at any time.

Medical Professional Signature Date

X

PATIENT CONSENT

In signing this **test** request, I confirm that I understand and provide my permission for EDX Medical Ltd (Company) and it's partners to securely store and access my information for the following purposes. I accept that the Company is not responsible for the actions of partner organisations.

- My referring doctor, named herein, has discussed the purpose of the **test** and this form with me and I agree to undergo the test. I grant the Company permission to share my **test** report with them and their employer.
- I consent to the Company holding my information and sharing such information as needed and as detailed herein, with partners including; the referring doctor, their employer, a blood sample collection service, insurer/payer of the test including bank provider if self-paid, and the custodian of my medical records.
- I consent to the Company using my **test** data without any personal details for medical research and sharing with selected partners.

Once the test is performed and report issued you may contact datacontroller@edxmedical.com to request a copy of all your personal information held by the Company and may also request its deletion.

Patient Signature Date

X

BILLING INFORMATION			
Hospital/Clinic	Department	Account Number.	Requisiton ID

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TEST TYPE

☐ M371 ☐ Classical tumour markers (AFP, ß-hCG, LDH)

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