mir-THYpe full

Test Requisition Form

CAP ACCREDITED COLLEGE of AMERICAN PATHOLOGISTS

onkos

PATIENT INFORMATION

*Can be filled in by the patient | Required fields**

Full name*

ID*

Date of Birth* / /

Biological sex* M ☐ F ☐

City*

Country*

(CODE) Cell phone* ( )

E-mail(s) for sending the medical report and notifications*

ABOUT THE TEST

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MOLECULAR CLASSIFIER TEST FOR INDETERMINATE NODULE

Primary Indication: Bethesda III or IV

Help the medical decision between clinical follow-up without surgery or the indication and planning of surgical extension.

Diagnostic Markers

Panel of microRNAs ("benign" vs "malignant")

Prognostic Markers

- *BRAF V600E*
- *TERT C228/250T*
- miR-375 (Medullary)
- miR-146b

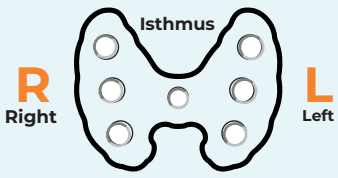
Materials accepted for analysis

- ✓ FNA (cytology smear slides)
- ✓ Cell-Block, Core Biopsy/TruCut up to 1 year from collection
- ⚠ *AP post-surgical is **NOT** accepted for this test*

CLINICAL INFORMATION OF THE SAMPLE TO BE ANALYZED

*Must be filled by the requesting physician**

Mark the location of the target node*



☐ CERVICAL LYMPH NODE
Location:_____

Fill a **single application per node*

Sample report date* / /

Laboratory, Clinic or Hospital where the sample was prepared*

Does the patient have more than 1 punctured nodule?*

○ No ○ Yes *(Specify the code - **as in the report** - of the nodule to be analyzed):* _____

Which is the Bethesda category of the target nodule?

○ Bethesda 3 ○ Bethesda 5

○ Bethesda 4 ○ Bethesda 6

Target nodule size (cm): _____

US category (ACR TI-RADS): _____

Other information: _____

ATTENTION: If the patient has more than one nodule (or more than one FNA of the same nodule), specify above the date and the same ID/code/number used in the report to identify the nodule to be analyzed.

REQUESTING PHYSICIAN

*Must be filled by the requesting physician | Required fields**

Full Name*

Physician Registry ID*

(CODE) Cell phone* ( )

City*

Country*

E-mail(s) of the physician to send the medical report*

Medical Specialty*

☐ Endocrinology ☐ Head and Neck Surgery ☐ Gynecology

☐ (Cyto)Pathology ☐ General Surgery / Oncology ☐ Oncology

☐ Radiology ☐ Other (Specify): _____

Signature

X *I request the molecular test selected above for the patient specified above*

_____

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