



Her2 FISH test

| | |
|----------------------------|--|
| Methodology | Fluorescent In-Situ Hybridization (FISH) Probes: |
| Name And Description: | - HER 2 - CEP 17 |
| Specimen Requirements: | FFPE Slides: H&E slide (required) plus 4 unstained FFPE slides cut at 5 microns. Circle tumor area on H&E slide for tech-only. |
| Clinical Significance | Amplification and overexpression of the oncogene <i>HER2</i> occurs in 20-30% of human invasive breast carcinomas. <i>HER2</i> amplification is associated with a significant reduction in metastasis-free survival, and similarly staged patients without <i>HER2</i> gene amplification have a high likelihood of remaining cancer-free years after removal of the primary tumor. <i>HER2</i> positive patients are more likely to respond to regimens containing adriamycin and less likely to respond to tamoxifen. Furthermore, patients with metastatic breast carcinoma whose tumors have amplification of the <i>HER2</i> gene may benefit from therapy with the humanized monoclonal antibody trastuzumab (Herceptin) either as a single agent or in combination with other chemotherapy. |
| Storage and Transportation | Transport the slides secured in slide holder. |
| Days Performed: | Monday – Friday (CMCD Holidays Excluded) |
| Reported: | 3 Days from receipt of acceptable specimen in lab |
| CPT Code(s): | 88368 (x2) Manual |

CLIA# 36D2061372
CAP# 7541618

ADDRESS: 8285 Darrow Road, Ste 101 Twinsburg, OH 44087
PHONE: 330-405-2623



Center for Molecular
Cancer Diagnostics, Inc.

| LAB USE ONLY | |
|--------------|------------|
| Received by | |
| Date Rec'd | Time Rec'd |

| ACCOUNT INFORMATION | PATIENT INFORMATION |
|--|--|
| Account No. <input type="text"/> Phone No. <input type="text"/> | Last Name <input type="text"/> MI <input type="text"/> |
| Treating Physician <input type="text"/> UPIN No. <input type="text"/> | First Name <input type="text"/> |
| | Street <input type="text"/> |
| Requesting Physician Signature I certify that I intend to order the services indicated which I consider medically necessary for the diagnosis and treatment of the patient. In accordance with CMS guidelines, all laboratory orders must either be signed by the ordering physician on the requisition or be documented and signed in the patient's medical record. | City <input type="text"/> State <input type="text"/> Zip <input type="text"/> |
| Duplicate Report To: <input type="text"/> | Phone No. <input type="text"/> |
| Address: <input type="text"/> | Sex: <input type="checkbox"/> (M) <input type="checkbox"/> (F) DOB <input type="text"/> |
| Fax: <input type="text"/> | Patient ID No. <input type="text"/> Chart No. <input type="text"/> |

| BILLING INFORMATION | |
|---|--|
| Bill to: Select One | |
| <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Patient's Insurance <input type="checkbox"/> Physician Bill <input type="checkbox"/> Self Pay <input type="checkbox"/> Other Insurance | |
| PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD | |
| Patient is: <input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Other Dependent | |
| Primary Insurance Name: <input type="text"/> | Policy No. <input type="text"/> |
| Group No. <input type="text"/> | Insured's Name: <input type="text"/> |
| Address: <input type="text"/> | City: <input type="text"/> State: <input type="text"/> Zip: <input type="text"/> |
| Secondary Insurance Name: <input type="text"/> | Policy No. <input type="text"/> |
| Group No. <input type="text"/> | Insured's Name: <input type="text"/> |
| Address: <input type="text"/> | City: <input type="text"/> State: <input type="text"/> Zip: <input type="text"/> |

| SOLID TUMOR | |
|---|--|
| ICD-9 Code <input type="text"/> | Collection Date <input type="text"/> Specimen Submitted <input type="checkbox"/> DNA <input type="checkbox"/> FFPE |
| Specimen Type | |
| <input type="checkbox"/> Colorectal Cancer <input type="checkbox"/> GI Cancer <input type="checkbox"/> Glioma <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Bladder Cancer <input type="checkbox"/> Other | |
| Test Requested | |
| <input type="checkbox"/> Bladder Cancer FISH <input type="checkbox"/> Her2-neu FISH | |
| Additional Notes | |
| <input type="text"/> | |
| <input type="text"/> | |
| <input type="text"/> | |

| PATIENT REQUEST | |
|--|---------------------------|
| I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediates, Blue Shield, or other carriers any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original; and request payment of medical insurance benefits. | |
| Patient Signature <input type="text"/> | Date <input type="text"/> |