MELAGENIX
Precision Medicine

REQUESTING THE TEST
Risk assessment for malignant melanoma

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ORDERING PHYSICIAN Information

Last Name, First Name

Hospital/Clinic

Number and Street | ZIP Code and Town/City

Telephone Number | Fax Number

Email

PATIENT Information

Last Name, First Name

M ☐ F ☐ | Date of Birth

Gender

Number and Street | ZIP Code and Town/City

Telephone Number | Fax Number

Email

To be filled out by the Ordering Physician: MELANOMA DIAGNOSIS

Please include a copy of the pathology report.

Date of Diagnosis | Tumor Thickness in mm (mm) | Lymph Node Status | Ulceration: Yes ☐ No ☐ | AJCC Stage

PATHOLOGIST Information

Please identify the person-in-charge, from whom the paraffin block of the tissue sample can be collected.

Last Name, First Name | Laboratory/Hospital/Clinic

Number and Street | ZIP Code and Town/City

Telephone | Fax | Email

Should the sample be sent back to the pathologist? Yes ☐ No ☐

Patient instruction and notification of result

Complementary to conventional AJCC staging, the MelaGenix test provides validated information about the risk of relapse, survival probability and need for treatment. The result is a probability calculation with a statistical margin for error; therefore, liability cannot be assumed.

We would like to be notified on the availability of the result by:

Mail ☐ Fax ☐ Email ☐

Medical Authorization

I hereby confirm that I am currently treating the above-mentioned patient and have thoroughly discussed the MelaGenix gene expression test with this patient. I am issuing this order for the MelaGenix Test because I regard the Test as medically necessary for further treatment of this patient. This Order Form together with required supporting documents shall be part of the patient file.

Signature of Ordering Physician | Place, Date

Patient Consent

This is to confirm that I have received thorough information about the MelaGenix gene expressions test including its medical significance and potential consequences regarding my treatment. I hereby authorize my consulting physician, whose name appears above, to order the test and receive the results on my behalf. I consent to the use of my tissue sample for the purpose of the MelaGenix test procedure. I agree to the processing of the test results in anonymized form. Furthermore, I have read the Terms of Services of the MelaGenix Test and its provider NeraCare GmbH and guarantee to pay the full cost of the MelaGenix Test should reimbursement be declined by my insurance provider.

Signature of Patient | Place, Date