INSTITUT FÜR HISTOLOGISCHE UND ZYTOLOGISCHE DIAGNOSTIK AG AARAU

Dammweg 1
CH-5000 Aarau

Phone +41 62 834 02 80

mychoice@patho-diagnostik.ch
www.patho-diagnostik.ch

Request for myChoice® CDxPLUS

Molecular pathological examination for genomic instability in the tumour tissue

Last name _____

First name _____ F ☐ M ☐

Date of birth _____ **External sample number** _____

Street/no. _____

Postal code/city _____

Health insurer _____ **Insurance number:** _____

Invoice to ☐ **Client** ☐ **Patient**

Clinical information (to be completed by the requesting physician)

I confirm that I have spoken to the aforementioned patient about the requested examination and the possible scope of results.
The informed consent of the patient was signed and is enclosed with the request.

_____ _____ _____

Date | Name of requesting physician (block letters) | Signature of requesting physician

Required material (to be provided by the responsible pathology institute)

Please send the following items in full to the address below:

- ☐ this request form
- ☐ informed consent of the patient
- ☐ histopathological findings of the material sent
- ☐ paraffin block (at least **30% tumour tissue**)
- ☐ section HE colored

Versandadresse: Institut für histologische und zytologische Diagnostik AG Aarau
c/o Dr. med. Steffen Bergelt
Dammweg 1
CH-5000 Aarau

The test result and the tissue block will be returned to the requesting institute of pathology in a timely manner as part of the normal transmission of diagnostic findings.

Name and stamp of doctor/hospital:

Date of sampling:

_____

☐ Email report: _____
(HIN encrypted email addresses only)

Copy(ies) to: _____

INSTITUT FÜR HISTOLOGISCHE UND ZYTOLOGISCHE DIAGNOSTIK AG AARAU

Dammweg 1
CH-5000 Aarau

Phone +41 62 834 02 80

mychoice@patho-diagnostik.ch
www.patho-diagnostik.ch

Informed Consent for Myriad myChoice® CDxPLUS

About Myriad myChoice® CDxPLUS

Myriad myChoice® CDxPLUS is a comprehensive test for homologous recombination deficiency (HRD). This test can be used to identify tumours that are no longer capable of repairing double-stranded DNA breaks. This results in a heightened susceptibility to DNA-damaging drugs such as platinum medicines or PARP inhibitors. The myChoice® CDxPLUS test comprises the tumour sequencing of the BRCA1 and BRCA2 genes as well as a composite of three proprietary technologies (loss of heterozygosity, telomeric allele unevenness and large-scale state transitions).
For more information go to: https://myriad-oncology.com/mychoice-cdx/

Patient data:

Last name: _____

First name: _____

Date of birth: _____

I confirm that I have been informed of the aspects of a genetic examination method, in particular of the Myriad myChoice® CDxPLUS test as part of genetic counselling. My questions were answered, and I have understood everything.
I am aware that this test can only be performed at Myriad Genetics in the United States at present.
After a sufficient period for consideration, with my signature, I give my consent to the performance of the genetic analysis and to the transmission of my test material and my data to the United States in anonymised form.

I give my consent that my test material and the data collected be allowed to be used in anonymised form for scientific purposes and publications.	□ Yes	□ No
I want to be notified of incidental findings that are not connected to the issue but have clinical significance if:		
- preventive measures and measures for treatment are known	□ Yes	□ No
- no therapy is known up till now	□ Yes	□ No
I wish the test to be performed even if the health insurer does not cover the costs. In this case I will bear the costs myself.	□ Yes	□ No

City, date:

Signature of patient/legal representative: