# BRCA TEST REQUEST AND CONSENT FORM FOR PARP INHIBITOR SELECTION

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|---|---|---|
| **Surname:** | | **First Name:** |
| **Date of Birth** | **MRN/Hospital Number** | **Gender:** |
| **Residential Address:** | | |
| **Referring Medical Oncologist (first name, surname, and hospital):** | | **Person requesting test** |
| **Contact Email Address:** | **Clinical Team Email Address:** | **Pathology Email Address:** |

**DETAILS OF TEST REQUESTED:**

**Ovarian/Fallopian tube/peritoneal**

□ Combined germline and tumour BRCA and MLPA*
(EDTA blood & FFPE tumour block to same testing site)
□ Germline BRCA only (EDTA blood)
□ Tumour BRCA only (FFPE tumour block)

**Breast**

□ Germline BRCA only (EDTA blood only)

**Prostate**

□ Tumour BRCA and MLPA with reflex gBRCA if required*
(EDTA blood & FFPE tumour block to same testing site)

**CURRENT DIAGNOSIS (tick one):**

**Ovarian/Fallopian tube/peritoneal**

□ High grade serous epithelial ovarian cancer
□ High grade endometrioid ovarian cancer
□ Fallopian tube cancer
□ Primary peritoneal cancer

**Breast**

□ HER2 negative locally advanced or metastatic breast cancer (germline BRCA test only)

**Prostate**

□ mCRPC (tBRCA and MLPA with reflex gBRCA if tBRCA positive or tBRCA fails)

*For germline and tumour requests complete the form in full and include a copy of the form with the blood sample and send a photocopy to histopathology to include with block referral.

**CLINICAL INFORMATION:**

□ Patient is being considered for first line maintenance PARP inhibitor treatment of a platinum –sensitive tumour
□ Patient is being considered for maintenance PARP inhibitor treatment of a platinum-sensitive relapsed tumour
□ Patient is being considered for PARP inhibitor treatment of HER2-negative locally advanced or metastatic breast cancer.
□ Patient is being considered for PARP inhibitor treatment of mCRPC following progression on prior therapy that included a new hormonal agent.

**To be completed by patient**

- I have read the written information given to me, understand the implications and limitations of the test, have discussed it with..... and consent to BRCA gene testing of my blood and/or tissue sample **YES / NO (please circle)**
- I consent that DNA from my blood and/or tissue sample will be stored in the Beaumont Hospital laboratory as standard practice, unless I request its disposal **(YES/NO) (please circle)**
- I consent that my genetic test result can be made available for use in counselling other family members **YES/NO (please circle)**
- I consent for this sample to be used for quality assurance and audit purposes **YES/NO (please circle)**
- If I am unable to receive the results of the test, I would like the result to be given to the following person(s)

Name: ..... Relationship:..... Contact no:.....

**Signed:** ..... **Date:** .....

For **completion by referring doctor:**

- I have discussed this test with my patient and they understand the implications of the test and the potential need for referral to the cancer genetics service.

Signature..... Name (block capitals).....

Contact Number..... Medical Council Registration Number: .....

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| Sample Details (complete as appropriate) | |
|---|---|
| **Germline or MLPA (blood) samples** | **Tumour/FFPE samples** |
| □ Blood Sample (>3ml EDTA)<br><br>□ Tube labelled with patient name, DOB and MRN<br><br>Sample Taken by (Full Name):<br><br>Date Taken:<br><br>Signature: | **Ovarian**<br>□ Pre-chemotherapy biopsy sample (preferred)<br>□ Post-chemotherapy biopsy sample<br><br>**Prostate**<br>□ Pre-chemotherapy biopsy sample<br>□ Post-chemotherapy biopsy sample<br>Age of sample (years):<br><br>**All samples**<br>□ Pathology report attached (required)<br><br>Pathologist name (Full Name):<br><br>Hospital Name:<br><br>Case Number:<br><br>Signature: |

**For Germline testing only:**

- Sample required is 3-5ml of venous blood in EDTA anticoagulant. Send at room temperature by courier to: Beaumont Hospital Molecular Pathology Laboratory, Beaumont Hospital, Dublin 9, D09 V2N0. Refrigerate if there will be more than a 24 hr delay before posting. DO NOT FREEZE.
- Note the minimum identification requirements for genetic testing are
  a) patient's forename & surname and date of birth or medical record number
  b) these identifiers must be present on the sample tube and the genetic test request form and must match exactly.
- Queries regarding the sample, sample identification requirements or transport should be directed to biomarkers@beaumont.ie / 01-809 3726

**For tumour testing only:**

- Complete this form.
- Forward the form to the histopathology laboratory where the material resides for block selection. A pathologist will review the available material and select the most appropriate block for testing.
- Arrange for this block along with a copy of the Pathology report to be sent to Beaumont Hospital Molecular Pathology Laboratory.
- A copy of the tumour report will also be sent to the histopathology laboratory for their records.

**For combined tumour and germline testing:**

- Complete form and photocopy.
- Include one copy of the form with the blood sample.
- Forward a second copy of the form to the histopathology laboratory where the material resides for block selection.
- A copy of the tumour report will be forwarded to the histopathology laboratory however the germline results and integrated report will only be forwarded to the requesting oncologist.

**Information for Pathologists:**

- Please indicate if it is a pre-chemotherapy or a post-chemotherapy biopsy sample as this may impact testing outcome
- Please select the block with the largest tumour content (ideally >50% high grade serous carcinoma tumour nuclei content, with minimal necrosis for ovarian samples and block with highest tumour cellularity available for prostate samples), however please note this will be re-assessed at the reference lab also)
- Sending of samples should be prioritised.
- Send the sample with a copy of the histopathology report by courier to: Beaumont Hospital Molecular Pathology Laboratory, Beaumont Hospital, Dublin 9, D09 V2N0.