

TEST REQUISITION FORM

Please complete this test requisition form fully and return it with the Cxbladder® sample. Failure to do so may delay the test result. For further assistance, contact Cxbladder customer service (see over for details).

I. SAMPLE INFORMATION (REQUIRED)

Test Required: Cxbladder Triage Cxbladder Detect Cxbladder Monitor

Sample Collection Date: _____ / _____ / _____ Collection Time: _____ AM / PM
DAY MONTH YEAR

II. PATIENT INFORMATION (REQUIRED)

Last Name: _____ Title: _____
 First Name: _____ Middle Initial(s): _____ Gender: Female Male
 Date of Birth (DAY/MONTH/YEAR): _____ Patient NHI No: _____
 Address: _____
 City/Town: _____ Postcode: _____ Phone Number: _____

III. IMPORTANT PATIENT HISTORY – ALL INFORMATION REQUIRED FOR CXBLADDER TRIAGE

<p>Haematuria History (answer both questions)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have microscopic haematuria?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had macrohaematuria (visible blood in the urine) <i>more than once per day</i> anytime within the last 12 months?</p>	<p>Smoking History</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient smoked <i>more than</i> 100 cigarettes in their lifetime?</p>
---	---

IV. IMPORTANT PATIENT HISTORY – ALL INFORMATION REQUIRED FOR CXBLADDER MONITOR

Does the patient have a prior history of Urothelial Carcinoma (UC)? (Tick one) Yes No *If No, then request Cxbladder Triage or Cxbladder Detect*

When was the last diagnosis of UC for the patient? _____ / _____ / _____
DAY MONTH YEAR

Note: Diagnosis of UC may be histopathological confirmation of resected tissue, biopsy or tissue visualised and treated by fulguration

What was the most recent diagnosis of UC? (Tick one) Primary disease Recurrent disease

V. HEALTHCARE PROFESSIONAL INFORMATION (REQUIRED)

<p>Nominated Healthcare Professional (GP and/or Specialist):</p> <p>Name: _____</p> <p>MCNZ/AHPRA No: _____</p> <p>Practice: _____</p> <p>EMR / Healthlink EDI: _____</p> <p>Address: _____</p> <p>City/Town: _____</p> <p>Email: _____</p> <p>Phone: _____ Fax: _____</p>	<p><input type="checkbox"/> Additional Healthcare Professional:</p> <p>Name: _____</p> <p>MCNZ/AHPRA No: _____</p> <p>Practice: _____</p> <p>EMR / Healthlink EDI: _____</p> <p>Address: _____</p> <p>City/Town: _____</p> <p>Email: _____</p> <p>Phone: _____ Fax: _____</p>
---	--

Results: Default method for results transmission is electronic (via HealthLink or Lab), unless alternative transmission method selected.

Alternative transmission: Download (ShareFile) Fax Mail Alternative transmission: Download (ShareFile) Fax Mail

VI. HEALTHCARE PROFESSIONAL'S COMMENTS

PLEASE FOLLOW ALL RELEVANT SAMPLE PREPARATION AND SHIPPING INSTRUCTIONS ON THE INSTRUCTIONS FOR USE LEAFLET PROVIDED

Contact Cxbladder Customer Service:

Email: customer.service@pacificedgedx.com

Tel (NZ): 0800 CXBLADR (0800-2925-237)

Tel (AUS): 1800 CXBLADR (1800-2925-237)

Web: www.cxbladder.com

SHIPPING INVENTORY

Diagnostic specimen; not restricted, packaged in accordance with IATA 650 packaging instruction.

- **Urine Sample** (human, non-infectious).