TEST REQUEST FORM

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

Proteocyte AI

STRATICYTE™ Predict Oral Cancer Risk

PATIENT INFORMATION

PATIENT NAME (SURNAME, NAME) | **MRN**

ADDRESS

CITY | **PROV / TERR** | **POST CODE**

DATE of BIRTH (DD-MMM-YYYY)

SEX at BIRTH
☐ DECLINE to ANSWER
☐ FEMALE ☐ MALE

PHONE

EMAIL

PHYSICIAN & CLINIC INFORMATION

PHYSICIAN NAME | **LISC #**

ADDRESS

CITY | **PROV / TERR** | **POST CODE**

MAIN PHONE | **MAIN FAX**

CLINIC Mgr / Dir PHONE (direct line) | **CLINIC Mgr / Dir FAX** (if separate; direct line ONLY)

EMAIL direct work email: *NO general inbox / personal email (gmail, proton, outlook, hotmail, etc)*

Clinic Mgr :

Physician :

BIOPSY INFORMATION

SPECIMEN / ACCESSION #

☐ Pathology Report(s) attached

☐ Biopsy images attached
No pics?, ref in Notes & Concerns

BIOPSY DATE (DD-MMM-YYYY)

TYPE
☐ INCISION
☐ EXCISION

SITE to specify location (left/right; upper/lower; anterior/posterior; ventral/dorsal; medial/lateral; etc) *use 'Other' field*
☐ LIP ☐ TONGUE ☐ BUCCAL ☐ Tooth Area?_____
☐ PALATE ☐ FLOOR ☐ GINGIVA ☐ *Other* _____

ICD.10.CA
☐ **D3702** Neoplasm of tongue, unknown
☐ **K132** Leukoplakia / other dist, incl tongue
☐ **K137** Lesions; oral mucosa, unspecified
☐ **K149** Disease of tongue, unspecified

LESION(s) ☐ Red ☐ White ☐ Mixed
☐ *Other* _____

DYSPLASIA
☐ LOW-GRADE ☐ HIGH-GRADE
☐ MILD ☐ MODERATE ☐ SEVERE
☐ NONE ☐ *Other* _____

NOTES / CONCERNS (OPMD Dx; Patient Hx; Family Hx; Lifestyle Fx; Concurrent Dx; Previous Bx, etc)

STRATICYTE INFORMATION — TEST REQUESTED

Uses a proprietary algorithm from a cohort of known outcomes to **assess the patient's individual STRATICYTE Risk Score: the 5-year probability of their OPMD** (oral potentially malignant disorder) **progressing to an OSCC** (oral squamous cell carcinoma). STRATICYTE acts as an adjunct to the corresponding Pathology report. *This test is not appropriate for lesions diagnosed as carcinoma*

AUTHORISED SIGNATURE

I hereby authorise testing and confirm that informed consent has been obtained from the patient, for relevant information to be released to Proteocyte AI for fulfillment of the test. I attest that, as the Ordering Physician, I am authorised by law in the relevant jurisdiction to order the test requested herein. By signing this form, I further attest the patient meets inclusion criteria as stated in the 'Test Requested' section above, the information as provided in this form is correct and belongs to the patient named above. I have had a discussion prior to ordering this test, on the potential results, and have determined to use these results to guide patient management.

PHYSICIAN SIGNATURE | *PHYSICIAN NAME* *Lisc #* | **DATE** (DD-MMM-YYYY)

BILLING & PAYMENT

☐ Payment obtained at Clinic / send Invoice ☐ Payment outstanding / to be secured by Proteocyte*

*Personal information will be securely handled by Proteocyte AI for data processing, billing, reimbursement, and administration of services. The patient understands they may revoke their consent at any time by contacting Proteocyte AI at CLIENTSERVICES@PROTEOCYTE.COM 1-833-577-6836 (1-833-5-PROTEO)

Thank you for choosing STRATICYTE, and your commitment to improving OPMD patient care & outcomes.

Email: clientservices@proteocyte.com **Phone:** 1-833-5-PROTEO (1-833-577-6836) **Fax:** 1-855-566-0488