PROTEOCYTE DIAGNOSTICS INC. LABORATORY
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Straticyte™

TEST REQUEST FORM

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM

PATIENT INFORMATION			ORDERING PHYSICIAN		
PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)			NAME (LAST, FIRST)		
BIRTHDATE (DD/MM/YYYY)	SEX AT BIRTH ☐FEMALE ☐MALE ☐DECLINE TO ANSWER		OFFICE CONTACT (IF APPLICABLE)		
ADDRESS			ADDRESS		
CITY	PROVINCE/STATE	POSTAL/ZIP CODE	CITY	PROVINCE/STATE	POSTAL/ZIP CODE
DAYTIME PHONE NUMBER			PHONE	FAX	
E-MAIL			E-MAIL		

CLINICAL INFORMATION

Procedure (biopsy) Date (DD/MM/YYYY)	Site of Biopsy: ☐Lip ☐Tongue ☐Buccal mucosa ☐Floor of mouth ☐Soft/Hard palate ☐Other: _____

Final Diagnosis of Biopsy:

3-tier		2-tier
☐No dysplasia	☐Mild dysplasia	☐Low-grade
☐Moderate dysplasia	☐Severe dysplasia	☐High-grade
☐Other: _____		

Biopsy Type:
☐Incision
☐Excision

TEST REQUESTED

Straticyte – Uses a probability algorithm developed from an annotated cohort of reference cases to assess the 5-year probability of an oral potentially malignant lesion progressing to oral squamous cell carcinoma. It provides supplemental information for the corresponding pathology report. This test is not appropriate for lesions diagnosed as carcinoma.

SPECIMEN INFORMATION & RETRIEVAL

Surgical Specimen/Accession #	☐ Corresponding pathology report attached **PLEASE ATTACH A COPY OF THE CORRESPONDING PATHOLOGY REPORT**

AUTHORIZED SIGNATURE

I hereby authorize testing and confirm that informed consent has been obtained from the patient for relevant information to be sent to Proteocyte for testing. I hereby attest that the person listed in the Ordering Physician space above is authorized by law in the relevant jurisdiction to order the test requested herein. By signing this form, I attest that the patient meets the inclusion criteria stated in the Test Requested section above, the clinical information described on this form is correct and belongs to the patient named above. I have had a discussion prior to testing regarding the potential results of the test and determined to use the results to guide patient management.

_____ _____

ORDERING PHYSICIAN SIGNATURE | DATE (DD/MM/YYYY)

BILLING/PAYMENT INFORMATION

☐ Payment collected at office
☐ Payment collected by Proteocyte*

*Personal information will be securely handled by PatientCare Solutions Inc., a third-party vendor working in association with Proteocyte AI for data processing, billing, reimbursement, and administration of services. The patient understands that they may revoke their consent at any time by contacting PatientCare Solutions at 1-833-5-PROTEO

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