Asia Molecular Diagnostics Laboratory Limited
亞洲分子診斷實驗室有限公司

Sample Request Form

Hotline: 852-35896301
Email: enquiry@amdl.com.hk

Test Menu

NGS-based diagnostic test
□ ONCO/Reveal™ Dx Lung and Colon Cancer Assay
□ ONCO/Reveal™ Lung and Colon Cancer Panel
□ ONCO/Reveal™ Solid Tumor Cancer Panel

Basic Information

Patient Information	
Full Name:	
Date of Birth (dd/mm/yyyy)**:**	**Gender: M/F**
HKID/Passport No./others (please specify)**:**	
Contact (phone/email):	
Diagnosis and Patient History	
Clinical history:	**Clinical no.:**
Diagnosis of Cancer: □ Yes □ No	**Cancer type** (if any)**:**
Treatment Status:	
Previous Treatment:	
Referral Site Information	
Referral Site:	**Clinic ID:**
Referral Physician:	
Phone:	**Fax** (if any)**:**
Email (for reporting use)**:**	
Email (for reporting use)**:**	
Sample Information	
Sample Type:	

□ Paraffin blocks No. of blocks: _____	□ Paraffin slides □ Surgical samples □ Puncture samples No. of slides: _____	□ Extracted DNA DNA concentration (ng/uL) Qubit: _____ Nanodrop (if any): _____
□ blood No. of tubes: _____ Tube volume: _____		
□ others (please specify):		

***If sample type is paraffin blocks / paraffin slides**
Site of biopsy: _____
Preparation date (dd/mm/yyyy): _____ (Time: _____ (am/pm))
Send-out date (dd/mm/yyyy): _____ (Time: _____ (am/pm))

***If sample type is blood**
Blood collection date (dd/mm/yyyy): _____ (Time: _____ (am/pm))
Send-out date (dd/mm/yyyy): _____ (Time: _____(am/pm))

Remarks:

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Informed Consent

Physician Informed Consent:

I have explained to the patient and / or guardian the contents of this informed consent form and the nature, necessity, scope of testing, intended purpose, limitations, potential risks, etc. of the test, have answered questions from the patient and / or guardian, and have committed to protect the privacy of the patient. I have obtained the consent of the patient and / or guardian to carry out the test.

Patient Informed Consent:

I have read and fully understood the contents of this informed consent, including the nature, necessity, scope of testing, intended purpose, limitations, potential risks, etc. All questions have been answered by my Healthcare Practitioner. After careful consideration, I agree to conduct testing and submit the necessary information, and the test results will be sent to my physician.

I understand that the test results need to be comprehensively reviewed by the physician in combination with clinical information, and I accept the return visit. I understand that AMDL will retain the samples and data for review in accordance with the relevant regulations, and its handling methods will be carried out in accordance with the usage agreement below.

Further usage of samples and data:

I agree to provide my consent for further usage and storage of my remaining samples and data for testing after removing personally identifiable information for scientific research, technological innovation, and clinical research applications are legally compliant. I understand whether agreeing to the use of the remaining samples and data does not affect my acceptance of testing or other rights. I understand that I will not benefit directly from this agreement. I can request the withdrawal of the agreement at any time. After the withdrawal of the agreement, my remaining samples will be destroyed after the review storage period expires, and the corresponding data will be deleted after the review storage period expires (but the data that has been anonymized for group analysis or anonymous publication cannot be deleted or withdrawn).

Limitation and liability:

1. I understand that for any samples depletion resulting from unexpected factors (e.g. broken of blood collection tubes, abnormal testing reagents, etc), test user shall cooperate with testing institutions for the re-collection of samples. If test user agrees to re-collect samples, the testing institutions would not charge any extra service fee. If test user does not agree to re-collect samples, the service fee would not be refunded.
2. Testing institutions would send the reports according to the assigned date and time (starting from the date of acceptance by the institution). However, if any delay caused by the transportation or quality problems on sample, it is not the liability of the institutions.

Patient signature: Date (dd/mm/yyyy):	**FOR LABORARTORY USE ONLY** Recipient: Date received (dd/mm/yyyy):
Physician Signature: Date (dd/mm/yyyy):	Sample: □ Pass □ Fail Remarks: