ISET® CTC* & PATHOGEN TEST REQUEST FORM

ID No.

***CTC = Circulating Tumour Cell**

Blood (10 ml in EDTA) collection days for CTC testing Mon-Fri until 3 pm. Ring NIIM Clinic on 03 9804 0646 for appointment.

Blood taken	Blood filtered
Date/Time By	Date/Time By

1. PATIENT DETAILS

Title:	**Surname:**	**First name:**	**DOB:**	**Sex:**
Street:	**Suburb:**		**State:**	**Postcode:**
Phone:	**Mobile:**	**Email:**		

2. PRACTITIONER DETAILS

Name:	**Type of practitioner**:
Provider number:	**Practitioner email:**
Practice name:	**Practice address**
PRACTITIONER SIGNATURE:	**DATE:**

3. Primary Test requested **(tick one):** [ ] **CTC count** [ ] **Pathogen Screen**

CTC: Type of cancer / Stage / Screening	**CTC: Date of initial diagnosis** *[ ] Pathogen Test: History Questionnaire by phone*
Family history of cancer?	**Current symptoms?**

Previous Therapy	**Details**	**Dates**	**Current Therapy**	**Commencement date** dd/mm/yyyy
Surgery			Radiotherapy	
Radiotherapy			Chemotherapy	
Chemotherapy			Hyperthermia	
Hyperthermia			Intravenous Vit C	
IVC/ IV Curcumin			IV Curcumin	
Other Therapy			Other Therapy	

Please provide details:	**Please provide details:**

3. ISET® CTC TESTING & PATHOGEN SCREENING

[ ] **CTC count and Pathogen Screening** - microscopy AUD $ 850

[ ] Optional (paid later) – **Pathogen test follow-up: PCR-DNA Analysis:** AUD $ 250
(Fungal/Mould, Borrelia, Rickettsia, Babesia)

4. CONSENT: By signing below, I the person undertaking the test:

(i) Give my consent to the NIIM Lab to use the blood sample for medical testing and analysis, as per this request form and I relinquish any claim of ownership of the blood sample or any of its components;

(ii) I agree that CTC & Pathogen test results will be made available to the referring doctor(s) for discussion with me.

(iii) I understand that NIIM conducts CTC & Pathogen testing as part of a clinical study. The study has been approved by an NHMRC registered ethics committee, and is registered on the Australia New Zealand Clinical Trial Registry.

PATIENT SIGNATURE: **DATE:**

5. PAYMENT SECTION

[ ] VISA [ ] Mastercard	**CARD NUMBER**	**Expiry Date (mm/yy)**
Cardholder's name:	**Cardholder's signature:**	**Amount** **AUD $**

National Institute of Integrative Medicine (NIIM) ABN 15 095 139 209
Phone: +61 3 9804 0646 | Fax: + 61 3 9804 0513 | Email: karinried@niim.com.au | Web: www.niim.com.au