TEMPUS

Hereditary Cancer Test Requisition Form 2025.05.13

p: 800.739.4137 | f: 800.893.0276 | e: support@tempus.com

If information is incomplete or missing, testing may be delayed.

Powered by Ambry Genetics

A.PATIENT INFORMATION

Last Name	MI	First Name

DOB (MM/DD/YYYY)	Medical Record #	Biological Sex	Email	Phone
		☐ F ☐ M		

Address (Street, Unit)	City	State	Postal Code	Country

Ancestry

☐ Ashkenazi Jewish ☐ Black/African American ☐ East Asian ☐ Hispanic ☐ Middle Eastern ☐ Native American ☐ South Asian ☐ White/Caucasian ☐ Other:

B.ORDERING PROVIDER INFORMATION

Ordering Provider (full legal name)	NPI #

Facility Name	Tempus Account #	Email (required for report delivery)	Fax

Facility Address (Street, Unit)	City	State	Postal Code	Country

Additional person to be copied

Name	Email/Fax	Facility Name

Form completed by

Name	Email/Fax	Facility Name

C.TESTING OPTIONS

☐ **xG+ (CancerNext-*Expanded*®)** ☐ **xG (CancerNext®)**	☐ **Add +RNAinsight®**	xG+: 77-gene or xG: 40-gene hereditary cancer test, powered by Ambry Genetics. *Requires Blood (EDTA), Saliva, or Cultured Fibroblast (Cultured Fibroblast specimen requires the completion of the 'Test Requisition for Tissue Culturing' form).* +RNAinsight®: Supplemental germline RNA sequencing, powered by Ambry Genetics. *Requires Blood (PAXgene® tube required for RNA).*

☐ **Familial Variant Testing** (i.e. Cascade Testing) is offered at no additional cost for blood relatives (out to 3rd degree) of patients who are found to have a pathogenic or likely pathogenic variant on the Tempus xG (CancerNext®) or xG+ CancerNext-*Expanded*®) test. **No-cost testing is offered for 90 days from the original xG report date.** *Requires Blood (EDTA) or Saliva.*

D.SPECIMEN RETRIEVAL *See Tempus' specimen guidelines for collection instructions and further details.*

☐ **Blood /** ☐ **Saliva /** ☐ **Cultured Fibroblast**

☐ Mobile phlebotomy ☐ Send saliva kit to patient

Date of Collection: Specimen Collection Facility:

Patient status at time of specimen collection:

☐ Office/Non-Hospital

☐ Hospital Outpatient → ☐ Not yet discharged ***OR*** Discharge date:

☐ Hospital Inpatient

E.CLINICAL HISTORY

☐ Breast ☐ Colorectal ☐ Endometrial ☐ GI Polyps ☐ Hematologic* ☐ Ovarian ☐ Pancreatic ☐ Prostate ☐ No personal history of cancer ☐ Other:

**Blood or saliva samples may not be appropriate for patients with active hematologic malignancies.*

Stage: ☐ I ☐ II ☐ III ☐ IV Other: **Age at diagnosis:** **Primary ICD-10 Codes (C, D, & Z codes):** **Additional details (pathology, number of polyps, etc.):**

Other patient history:

Personal history of allogeneic bone marrow or peripheral stem cell transplant:** ☐ Yes ☐ No

***Using a blood or saliva sample is not appropriate for patients who have undergone an allogeneic bone marrow or peripheral stem cell transplant.*

F.BILLING INFORMATION

Primary insurance plan name	Policy #	Group#	Policy Holder Name	Policy Holder DOB

Patient relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Bill Type: ☐ Insurance ☐ Hospital/Institution ☐ Self pay/International

G.FAMILY HISTORY

☐ **None/No known family history** ☐ **Unknown** ☐ **Adopted**

Relationship to patient	Maternal	Paternal	Age at diagnosis	Details of relevant history
	☐	☐		
	☐	☐		
	☐	☐		

H.PRIOR PERSONAL OR FAMILY HISTORY OF GENETIC TESTING

☐ No personal or family history of molecular and/or genetic testing.

Relationship to patient: ☐ Self ☐ Family member:

Microsatellite instability analysis: ☐ Stable (MSS) ☐ Unstable/High (MSI-High) ☐ Unstable/Low (MSI-Low)

☐ Germline testing
Test performed: Results:

☐ Somatic/tumor testing (including potential germline findings)
Test performed: Results:

☐ Immunohistochemical staining
Proteins present: Proteins absent:

I.FAMILIAL VARIANT TESTING INFORMATION *Section is required if ordering FVT testing.*

Proband Name	Proband DOB (MM/DD/YYYY)	Relationship to Proband	Proband Accession #

Variant Information *Attaching the family member's test report is recommended.* **No. of Variants:**

Gene	Coding DNA (c.)	Amino Acid (p.)	Transcript (NM#)

J.ORDERING PROVIDER/GENETIC COUNSELOR'S SIGNATURE AND CONSENT

I certify that the patient has received an explanation of the purpose, risks, and benefits of the ordered test(s). My signature below certifies medical necessity of the test(s) (including that the test results will inform the treatment plan) and that the patient has provided informed consent that meets the requirements of applicable law for Tempus or its reference lab to: **(a)** collect and use the patient's samples (including genetic material) and health information and perform the ordered test(s); **(b)** obtain, receive, and release health information (including test results) as necessary for reimbursement or the processing of insurance claims; **(c)** retain and use samples and health information for an indefinite period of time in accordance with applicable law; and **(d)** de-identify such samples and information and use and share the resulting de-identified samples and information in accordance with applicable law.

Ordering Provider's Signature: **Printed Name (full legal name):** **Today's Date (MM/DD/YYYY):**