FAX: 800.893.0276 | EMAIL: support@tempus.com

Supplemental information is required for all orders of xG Hereditary Cancer Panel.

PATIENT INFORMATION			
Last Name	First Name	Middle Name	DOB (MM/DD/YYYY)

PATIENT CANCER HISTORY

☐ No personal history of cancer

Diagnosis	Age at Diagnosis

FAMILY HISTORY

☐ None / No Known Family History ☐ Unknown ☐ Adopted

Relationship	Maternal	Paternal	Relevant History	Age at Diagnosis
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

ANCESTRY

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

BONE MARROW TRANSPLANT

Personal history of allogenic bone marrow or peripheral stem cell transplant: ☐ Yes ☐ No Note: Using a blood or saliva sample is **not appropriate** for patients who have undergone a bone marrow transplant.

PRIOR PERSONAL OR FAMILY HISTORY OF GENETIC TESTING

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

☐ Germline testing Tests performed: ____________ Results: ____________

☐ Somatic/tumor testing Tests performed: ____________ Results: ____________

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

☐ Immunohistochemical staining Proteins present: ____________ Proteins absent: ____________

Relationship to patient: ☐ Self ☐ Family member: ____________