TEMPUS xG HEREDITARY CANCER REQUISITION FORM – 2022.09.15

Phone: 800.739.4137 | Fax: 800.893.0276 | support@tempus.com

A. PATIENT INFORMATION (REQUIRED)

Last Name	First Name	Middle Name
DOB (MM/DD/YYYY)	Patient Medical Record #	Sex ☐ M ☐ F
Email Address		
Street Address, Unit		
City	State	Postal Code
Country	Primary Phone #	

B. ORDERING PHYSICIAN/GENETIC COUNSELOR INFORMATION (REQUIRED)

Office / Practice / Institution Name / Clinic		Account #
Street Address, Unit		City
State	Postal Code	Country
Phone	Fax	
Ordering Physician/Genetic Counselor	NPI #	
Email Address (required for report delivery)		

A.1 ANCESTRY

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

C. GERMLINE TESTING OPTIONS

☐ **xG+ (extended hereditary cancers) – 88 genes**
☐ **xG (common hereditary cancers) – 52 genes**

(Powered by GeneDx)

D. SPECIMEN RETRIEVAL

Specimen Type ☐ Blood ☐ Buccal Swab | Date of Collection | Section A must be completed for these options. ☐ Mobile phlebotomy ☐ Send buccal swab kit to patient

E. CLINICAL HISTORY

Cancer Type

☐ No personal history of cancer

☐ Breast ☐ Ovarian ☐ Prostate ☐ Pancreatic ☐ Colorectal ☐ Endometrial ☐ Hematologic* ☐ GI Polyps ☐ Other: _____

*Blood or buccal swab samples may not be appropriate for patients with active hematologic malignancies

Age at Diagnosis	ICD-10 Primary Diagnosis Code(s) (REQUIRED)	Additional Details (pathology, number of polyps, etc.)	Stage

Other Patient History

F. BONE MARROW TRANSPLANT

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

Note: Using a blood or buccal sample is **not appropriate** for patients who have undergone an allogenic bone marror or peripheral stem cell transplant.

G. FAMILY HISTORY

☐ None / No Known Family History ☐ Unknown ☐ Adopted

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

H. 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: _____

** including xT incidental germline findings

☐ 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: _____

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I. BILLING INFORMATION

Primary Insurance		Policy #	Group #
Policy Holder Name	Policy Holder DOB	Patient Relationship to Policy Holder	☐ Self ☐ Spouse ☐ Child ☐ Other
Bill Type ☐ Insurance (must attach copy of card) ☐ Medicare - Part B ☐ Hospital/Institution ☐ Self Pay/International Patient		Patient Status (for Medicare patients)	☐ Hospital Inpatient Date of Discharge: _____

ORDERING PHYSICIAN/GENETIC COUNSELOR SIGNATURE 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.

J. ORDERING PHYSICIAN/GENETIC COUNSELOR SIGNATURE

Ordering Physician/Genetic Counselor's Signature	Date (MM/DD/YYYY)
Printed Name	

K. FORM COMPLETED BY

Name
Email

L. ADDITIONAL PHYSICIAN/GENETIC COUNSELOR TO BE COPIED

Name	Email / Fax	Office / Practice / Facility Name

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