

Associated Study:	Study ID:
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A. PATIENT INFORMATION (REQUIRED)		
Last Name	First Name	Middle Name
DOB (MM/DD/YYYY)	Patient Medical Record #	Sex M      F
Street Address, Unit		
City		State
Postal Code		Country
Email Address		Primary Phone

B. ORDERING PHYSICIAN INFORMATION (REQUIRED)		
Office / Practice / Institution Name / Clinic		Account #
Street Address, Unit		City
State	Postal Code	Country
Phone		Fax
Ordering Physician		NPI #
Email Address (required for report delivery)		

C. TESTING OPTIONS (REQUIRED)		Optional add-on tests:	MMR IHC	PD-L1 IHC <sup>1</sup>	HRD	Tumor Origin	DPYD
xT Solid Tumor + Normal – 648 genes Add Concurrent xF Liquid Biopsy – 105 genes  xT Solid Tumor Only – 648 genes  xT Hematologic Malignancy – 648 genes  xF Liquid Biopsy – 105 genes  xG+ (extended hereditary cancers) – 88 genes xG (common hereditary cancers) – 52 genes	(Uses normal match blood sample)  (Blood, FFPE, or Bone Marrow Aspirate)  (Non-hematologic malignancies only)  (Order options are for either xG or xG+, not both) – Powered by GeneDx						
	Conversion to xF Liquid Biopsy 105 genes – If concurrent testing is not selected, you can opt-in to one of the following:						
	Convert to xF <u>immediately</u>						
	Convert to xF <u>after additional tissue request</u>						
<sup>1</sup> PD-L1 clone 22C3 is the default. For different clones, please select all that apply:  22C3    28-8    SP142    SP263							

D. SPECIMEN RETRIEVAL (REQUIRED)						
xT Solid Tumor	Option 1 – Specific specimen requested (Please provide specimen details below).		Option 2 – Let the submitting pathologist choose specimen.		Option 3 – Biopsy to be scheduled for:	
	Pathology Lab Name					
	Case Number	Block #	Solid Tumor Collection Date		Check here if the pathology lab is <b>not</b> part of the treatment team.	
xT Normal	Blood    Saliva	Date of Collection		Section A must be completed for these options.	Mobile Phlebotomy	Send saliva kit to patient <b>for xT Normal only</b>
xF Liquid Biopsy	Blood					Previously Submitted
xT Hematologic Malignancy	Blood (EDTA)    FFPE (Bone Marrow Biopsy, Bone Marrow Clot, Lymph Node, or other involved tissue)    Bone Marrow Aspirate (EDTA)	Date of Collection		Section A must be completed for these options. <i>Please see specimen instructions for details.</i>	Mobile Phlebotomy	Send saliva kit to patient
xG/xG+ Hereditary Cancer Panel	Blood (EDTA)    Buccal Swab	Date of Collection		Section A must be completed for these options.	Mobile Phlebotomy	Send buccal swab kit to patient

E. CURRENT DIAGNOSIS							
NSCLC	Melanoma	Prostate	Colorectal Carcinoma	Ovarian	Breast	Other:	
Disease Status (select all that apply):				Metastatic	Refractory	Relapse	Other:
ICD-10 Primary Diagnosis Code(s) – REQUIRED		Additional Details			Stage		

F. 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:

**PHYSICIAN 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.

G. PHYSICIAN SIGNATURE (REQUIRED)	
Ordering Physician's Signature	Date (MM/DD/YYYY)
Printed Name	

H. FORM COMPLETED BY
Name
Email

I. PHENOTYPIC ATTRIBUTES							
Cancer Type	Attribute (if cancer type selected)	Notes		Cancer Type	Attribute (if cancer type selected)	Notes	
Lung	Smoker	No	Yes	Breast	Pre-Menopause	No	Yes
Brain	Radiation Exposure	No	Yes	Breast	HER2 Status	Positive	Negative
Liver	Hepatitis C Positive	No	Yes	Breast	ER Status	Positive	Negative
Liver	Hepatitis B Positive	No	Yes	Breast	PR Status	Positive	Negative

J. CLINICAL INFORMATION   COMPLETE IF PROGRESS REPORT IS NOT ATTACHED.				
Radiation Treatment		Surgical Resection		
No	Yes – Start Date: _____ End Date: _____	No	Yes – Date: _____ Resection Score: _____	
Has the patient had any type of transplant?		Relapse / Recurrence		
No	Yes – Type: _____	No	Yes – Date: _____	
Cancer Medication(s)			No previous medications Other Clinically Significant Illnesses:	
Therapy: _____	Start Date: _____	End Date: _____		Response to Therapy: _____
Therapy: _____	Start Date: _____	End Date: _____		Response to Therapy: _____
Therapy: _____	Start Date: _____	End Date: _____		Response to Therapy: _____

K. ADDITIONAL PHYSICIAN TO BE COPIED		
Name	Email / Fax	Office / Practice / Facility Name

**REQUIRED FOR xG/xG+ ORDERS ONLY**

L. OTHER PATIENT CLINICAL HISTORY (PREVIOUS CANCER DIAGNOSIS, GI POLYPS, ETC.)

M. FAMILY HISTORY				
None / No Known Family History    Unknown    Adopted				
Relationship	Maternal	Paternal	Relevant History	Age at Diagnosis

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

O. 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 marrow or peripheral stem cell transplant.

P. 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:	

\*\* including xT incidental germline findings