TEMPUS HEREDITARY CANCER TEST REQUISITION FORM — 2023.12.05

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

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 PHYSICIAN INFORMATION

Ordering Physician (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		**Form completed by**	
Name	Email/Fax	Name	Email/Fax
Facility Name		Facility Name	

C. TESTING OPTIONS

Assay names	Test descriptions	Specimen required
☐ **xG+ (CancerNext-*Expanded*®)** ☐ **xG (CancerNext®)**	xG: 36-gene or xG+: 77-gene hereditary cancer test, powered by Ambry Genetics.	Blood (EDTA), Saliva, or Cultured Fibroblast *(cultured fibroblast specimen requires the completion of the Test Requisition for Tissue Culturing form).*
☐ **Familial Variant Testing**	Familial Variant Testing (i.e. Cascade Testing) is offered 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. ***Testing is offered for 90 days from the original report date.***	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	
Collection Date:	Collection Date:	Collection Date:

E. CLINICAL HISTORY

☐ Breast	☐ GI Polyps	☐ Pancreatic	☐ Other:	Stage	☐ I	☐ III	☐ Other:	Age at diagnosis	Primary ICD-10 Codes (C, D, & Z codes only)
☐ Colorectal	☐ Hematologic*	☐ Prostate			☐ II	☐ IV			
☐ Endometrial	☐ Ovarian	☐ No personal history of cancer							

Additional details (pathology, number of polyps, etc.)	Other patient history	Personal history of allogenic bone marrow or peripheral stem cell transplant:**	
		☐ Yes ☐ No	

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

***Using a blood or saliva sample is not appropriate for patients who have undergone an allogenic 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	Bill Type:	Patient Status (for Medicare patients)
☐ Self ☐ Spouse ☐ Child ☐ Other:	☐ Insurance ☐ Hospital/Institution ☐ Self pay	☐ Hospital Inpatient Date of discharge:

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:

☐ Germline testing

Test performed: Results:

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

☐ Somatic/tumor testing *(including potential germline findings)*

Test performed: Results:

☐ Immunohistochemical staining

Proteins present: Proteins absent:

FORM CONTINUES ON THE FOLLOWING PAGE; PLEASE DO NOT SKIP. IF INFORMATION IS INCOMPLETE OR MISSING, TESTING MAY BE DELAYED.

Phone: 800.739.4137 | Fax: 800.893.0276 | support@tempus.com
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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#)
Gene	Coding DNA (c.)	Amino Acid (p.)	Transcript (NM#)
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J. ORDERING PHYSICIAN/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 Physician/Genetic Counselor's Signature

Printed Name (full legal name)	Today's Date (MM/DD/YYYY)

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