

A. PATIENT INFORMATION

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

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

Name		Email/Fax	Form completed by	
Name			Name	
Facility Name			Facility Name	

C. TESTING OPTIONS

Common test combinations	Test descriptions	Specimen required	Optional add-on tests (select all that apply):	
xT (DNA) & xR (RNA): Solid Tumor/Normal	xT: 648-gene DNA sequencing test with normal match; xR: whole transcriptome RNA sequencing test.	FFPE Tissue; Normal: Blood or Saliva	xT Solid Tumor, xR LDT FFPE Tissue PD-L1 IHC: 22C3 DEFAULT 28-8 SP142 SP263 MMR IHC HRD* Tumor Origin (RNA) PurIST™ (RNA, Panc)	xT Normal Blood or Saliva DPYD UGT1A1
Add xF liquid biopsy at time of order, based on the following: I believe it is medically necessary to order a liquid biopsy test concurrently with a solid tumor tissue test because of one or more of the following reasons: (a) guidelines support the use of testing in this disease state; (b) turnaround time for tissue result may delay a treatment decision for my patient; (c) the tissue is at risk to fail (e.g. small tissue, archived tissue) and I may not have a timely result to make a treatment decision for my patient; (d) genomic heterogeneity may cause the patient's available tissue to not be completely representative, and I want to make sure I have a complete mutation profile. If I have not already ordered an xF test above, I opt to convert my xT solid tumor order to an xF liquid biopsy test if necessary: By converting immediately <i>OR</i> After an additional tissue request is attempted				
xT (DNA) & xR (RNA): Solid Tumor	xT: 648-gene DNA sequencing test; xR: whole transcriptome RNA sequencing test.	FFPE Tissue		
xT (DNA) & xR (RNA): Heme	xT: 648-gene DNA sequencing test; xR: whole transcriptome RNA sequencing test.	FFPE Tissue, Blood (EDTA), or Bone Marrow Aspirate (EDTA)		
Individual test options				
xR (RNA Only): Solid Tumor <i>OR</i> Heme	Whole transcriptome RNA sequencing test.	FFPE Tissue, Blood (EDTA), or Bone Marrow Aspirate (EDTA)	* Normal sample is required for ovarian or breast cancers.	
xT (DNA Only): Solid Tumor <i>OR</i> Heme	648-gene DNA sequencing test.	FFPE Tissue, Blood (EDTA), or Bone Marrow Aspirate (EDTA)		
xF (Liquid Biopsy): <i>OR</i> xF+ (Liquid Biopsy):	xF: 105-gene or xF+: 523-gene liquid biopsy test for solid tumors.	Blood (Streck)		
xG (CancerNext®) (Hereditary): <i>OR</i> xG+ (CancerNext-Expanded®) (Hereditary):	xG: 36-gene or xG+: 77-gene hereditary cancer test, powered by Amry Genetics.	Blood (EDTA), Saliva, or Cultured Fibroblast (cultured fibroblast specimen requires the completion of the Test Requisition for Tissue Culturing form).		

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

FFPE Tissue				
Option 1: Specific specimen requested	Option 2: Let the submitting pathologist choose specimen	Option 3: Biopsy to be scheduled for:	Pathology Lab (Name, City)	
			Case Number	Block # Date of Collection
Blood		Saliva	Bone Marrow Aspirate	
Mobile phlebotomy Date of Collection:	Sample previously submitted	Send saliva kit to patient Date of Collection:	Date of Collection:	

E. CURRENT DIAGNOSIS

Breast	NSCLC	Pancreatic	Other:	Primary ICD-10 Codes (C & D codes only)	Stage I III Other:
Colorectal	Ovarian	Prostate			II IV
Disease Status (select all that apply): Metastatic Relapse Other: Refractory Recurrent				Has the patient had any type of transplant? No Yes —Type:	Attachments Copy of patient's progress notes and/or medical records. Copy of recent pathology report. Copy of insurance card.

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	Patient Status (for Medicare patients) Hospital Inpatient Date of discharge:	

G. PHYSICIAN SIGNATURE AND CONSENT

My signature below certifies that (1) the patient has received an explanation of the purpose, risks, and benefits of the ordered test(s); (2) the ordered test(s) are medically necessary because the patient has been diagnosed with a cancer that is either recurrent, relapsed, refractory, metastatic, or advanced stage, and the test results will inform the patient's treatment plan; and (3) 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 Signature	
	Printed Name (full legal name)	Today's Date (MM/DD/YYYY)

