

A. PATIENT INFORMATION											
Last Name				MI	First Name						
DOB (DD/MM/YYYY)		Medical Record #		Biological Sex F M		Email		Phone			
Address (Street, Unit)				City		State	Postal Code	Country			
B. ORDERING PHYSICIAN INFORMATION											
Distributor				Ordering Physician (full legal name)				Phone			
Facility Name				Tempus Account #		Email (required for report delivery)		Fax			
Facility Address (Street, Unit)				City		Postal Code		Country			
Additional person to be copied											
Name				Email/Fax			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 <small>DEFAULT</small> 28-8 SP142 SP263 MMR IHC HRD* Tumor Origin(RNA)	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 OR 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					
xE (DNA) & xR (RNA):		Solid Tumor/Normal	xE: over 19,000-gene whole exome DNA sequencing test with normal match; xR: whole transcriptome RNA sequencing test.			FFPE Tissue; Normal: Blood or Saliva					
Individual test options											
xR (RNA Only):		Solid Tumor	Whole transcriptome RNA sequencing test.			FFPE Tissue					
xT (DNA Only):		Solid Tumor	648-gene DNA sequencing test.			FFPE Tissue		* Normal sample is required for ovarian or breast cancers.			
xF (Liquid Biopsy):		OR xF+ (Liquid Biopsy):	xF: 105-gene or xF+: 523-gene liquid biopsy test for solid tumors.			Blood (Streck)					
xE (DNA Only):		Solid Tumor/Normal	Over 19,000-gene whole exome DNA sequencing test with normal match.			FFPE Tissue; Normal: Blood or Saliva					
D. SPECIMEN RETRIEVAL <small>See Tempus' specimen guidelines for collection instructions and further details.</small>											
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											
Sample previously submitted Date of Collection:						Send saliva kit to patient 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.					
F. BILLING INFORMATION											
Primary Insurance Plan Name			Policy #		Authorisation #		Policy Holder Name		Policy Holder DOB		
Patient Relationship to Policy Holder Self Spouse Child Other:					Bill Type: Insurance Hospital/Institution Self pay/International						
G. PHYSICIAN 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 further certifies that I am authorized to order the test(s) 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 (if applicable); and (c) collect, use, and retain samples and information obtained from the patient, all in accordance with the Tempus Consent to Genomic Testing form signed by the patient.						Ordering Physician Signature					
						Printed Name (full legal name)			Today's Date (DD/MM/YYYY)		