

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

Form completed by

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

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: 648-gene DNA sequencing test with normal match;  
xR: whole transcriptome RNA sequencing test.

FFPE Tissue;  
Normal: Blood or Saliva

Tissue Based Add-Ons:  
  
PD-L1 IHC<sup>1</sup>:  
22C3 DEFAULT  
28-8  
SP142  
SP263  
MMR IHC  
HER2 IHC + FISH<sup>1,2</sup>  
FOLR1 IHC FDA<sup>2</sup>  
CLDN18 IHC FDA<sup>2</sup>  
c-MET IHC FDA<sup>2</sup>

Algorithmic Add-Ons:  
  
HRD<sup>1,3</sup>  
Tumor Origin (RNA)  
DPYD<sup>1</sup>  
UGT1A1<sup>1</sup>

1 See our Testing Resources website for IHC and FISH tests ordered by cancer type, and Algorithmic Add-On logistics.

2 Powered by a Tempus Partner Lab.

3 Normal sample is required for ovarian and breast cancers.

xT (DNA) & xR (RNA):Solid Tumor OR Heme

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 OR Heme

Whole transcriptome RNA sequencing test.

FFPE Tissue

xT (DNA Only):Solid Tumor OR Heme

648-gene DNA sequencing test.

FFPE Tissue

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

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

Sample previously submitted  
Date of Collection:

Send saliva kit to patient  
Date of Collection:

E. CURRENT DIAGNOSIS

BreastNSCLCPancreaticOther:

Primary ICD-10 Codes (C & D codes only)

Stage

I

III

Other:

ColorectalOvarianProstate

II

IV

Disease Status (select all that apply):  
MetastaticRelapseOther:  
RefractoryRecurrent

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  
SelfSpouseChildOther:

Bill Type:  
InsuranceHospital/InstitutionSelf 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 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)

Find the most recent documents at tempus.com/resources/document-library/2025-07

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