

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):	
<b>xT (DNA) &amp; xR (RNA): Solid Tumor/Normal</b>  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 <input type="checkbox"/> OR After an additional tissue request is attempted <input type="checkbox"/>	xT: 648-gene DNA sequencing test with normal match; xR: whole transcriptome RNA sequencing test.	FFPE Tissue; Normal: Blood or Saliva	<b>Tissue Based Add-Ons:</b> PD-L1 (22C3) <sup>1</sup> PD-L1 (28-8) <sup>1</sup> PD-L1 (SP142) <sup>1</sup> PD-L1 (SP263) <sup>1</sup> 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>	<b>Algorithmic Add-Ons:</b> HRD <sup>1,3</sup> Tumor Origin (RNA) DPYD <sup>1</sup> UGT1A1 <sup>1</sup>
<b>xT (DNA) &amp; xR (RNA): Solid Tumor OR Heme</b>	xT: 648-gene DNA sequencing test; xR: whole transcriptome RNA sequencing test.	FFPE Tissue		
<b>xE (DNA) &amp; xR (RNA): Solid Tumor/Normal</b>	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				
<b>xR (RNA Only): Solid Tumor OR Heme</b>	Whole transcriptome RNA sequencing test.	FFPE Tissue		
<b>xT (DNA Only): Solid Tumor/Normal OR Solid Tumor OR Heme</b>	648-gene DNA sequencing test.	FFPE Tissue; Normal: Blood or Saliva		
<b>xF (Liquid Biopsy): OR xF+ (Liquid Biopsy):</b>	xF: 105-gene or xF+: 523-gene liquid biopsy test for solid tumors.	Blood (Streck)		
<b>xE (DNA Only): Solid Tumor/Normal</b>	Over 19,000-gene whole exome DNA sequencing test with normal match.	FFPE Tissue; Normal: Blood or Saliva		

D. SPECIMEN RETRIEVAL <i>See Tempus' specimen guidelines for collection instructions and further details.</i>			
<b>FFPE Tissue</b>			
<b>Option 1:</b> Specific specimen requested	<b>Option 2:</b> Let the submitting pathologist choose specimen	<b>Option 3:</b> Biopsy to be scheduled for:	Pathology Lab (Name, City)
			Case Number      Block #      Date of Collection (DD/MM/YYYY):
<b>Blood</b>			
Sample previously submitted Date of Collection (DD/MM/YYYY):		Send saliva kit to patient Date of Collection (DD/MM/YYYY):	

E. CURRENT DIAGNOSIS			
Breast	NSCLC	Pancreatic	Other:
Colorectal	Ovarian	Prostate	
Primary ICD-10 Codes (C & D codes only)			Stage I III Other: 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 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)