Test Requisition Form

Patient Demographics

Last Name ____________ First Name ____________ DOB: DD/MM/YYYY ____________ Sex ☐ F ☐ M

Address ____________ City / State / Postal Code ____________ Country ____________ Phone ____________

Treating Physician Information

Facility Name ____________ Treating Physician Name ____________

Facility Address ____________ City /State /Pin code ____________ Country ____________

Phone ____________ Email ____________

Additional Physician to be Copied (optional) ____________ Facility Name ____________ Email ____________ Phone ____________

Current Diagnosis/ Patient History

Diagnosis: ☐ NSCLC ☐ Melanoma ☐ Colorectal Adenocarcinoma ☐ Ovarian ☐ Breast ☐ Other ____________

Disease Status (select as many as apply): ☐ Metastatic ☐ Recurrent ☐ Refractory ☐ Relapse

Subtype ____________ Stage _____

Earlier genomic tests /Targeted Therapies/ ____________

Attachments: ☐ Copy of recent pathology / cytology reports including (if available)

☐ Test results from all other Molecular Diagnostic Assays by FISH, IHC, or other genetic assays, e.g., ER, PR, HER2, EGFR, KRAS, etc.

Test Selection (Select one)

1. OncoCEPT- Solid ---------- FFPE block
2. If tissue is insufficient, reflex to liquid biopsy — OncoCEPT-Liquid ---------- (Streck tube) Whole Blood
3. CancerHotspot ---------- *Whole blood in EDTA*
4. ColoEssential (MSI/ MMR-IHC + BRAF) ---------- *FFPE/ whole blood in EDTA*
5. ColoCombine (MSI+MMR-IHC ---------- *FFPE/ whole blood in EDTA*
6. Breast panel. (BRCA1/2) ---------- *Whole blood in EDTA*
7. Other test(s) :Description of test and sample type- --

Family history of any cancer

S. No.	Type of cancer	Age of disgnosis	Relationship with patient	Mother's or father's side	Histopathology/ genetic test reports (if available)

Specimen Retrieval | Only one specimen can be tested per order

Date of Collection (MM/ DD/ YYYY) ____________ Specimen ID ____________

FFPE: Specimen Site ____________

☐ Please contact the pathology lab: Submitting Pathologist Name ____________ Facility Name ____________ Phone ____________

☐ Mobile Phlebotomy requested

Billing Information |

Self pay in cash (reference) ____________

Electronic payment (reference) ____________

Signatures for consent/ test authorization.

I certify that I am patient's treating physician and I consent that this test will aid in patient's ongoing treatment. I have explained the patient about nature and purpose of testing. Patient has given his consent to me for Neuberg center of genomic medicine to (1) perform tests mentioned here (2) retain the test results (3) de-identify the test report/ result for future research purpose.

I authorize Neuberg Center of Genomic Medicine to perform most appropriate test based on submitted histopathology report.

Treating Physician Signature ____________ Printed Name ____________ Date: DD/MM/Year ____________