TEMPUS

Test Requisition Form 11.6.2024 p: 800.739.4137 | f: 800.893.0276 | e: support@tempus.com If information is incomplete or missing, testing may be delayed.

Associated Study	Study ID			

	р	,,								
A.PATIENT INFORMATIO	N									
Last Name			MI	First Nar	me					
DOB (MM/DD/YYYY)	DB (MM/DD/YYYY) Medical Record # Biological Se								Phone	
Address (Street, Unit)		City			State		Postal Code	Country		
		·								
B.ORDERING PROVIDER	INFORMATION									
Ordering Provider (full legal name)									NPI#	
Facility Name		Tempus Account # Email (rec			quired for report delivery)				Fax	
Facility Address (Street, Unit)		City				State	Posta	al Code	Country	
Additional person to be copied			Forr	n completed	by					
Name	Email/Fax	Facility Name	Nan	ne		Email/Fax	x		Facility Name	
C.TESTING OPTIONS										
Common test combinations	Test des	criptions & specimen requ	iromonts				Ontio	nal add-on	testing options	
	VT: 649 d	ene DNA sequencing test with no		hole transcriptor	no PNA seguencing to	act		e Based Ad	• .	
xT (DNA) & xR (RNA): Solid Tum		FPE tissue w/ normal blood or sa		note transcriptor	ne Kivi sequencing to		I)-L1 IHC ¹	Immune Profile Score ¹	
Add an xF liquid biopsy test at the time	e of order. If I have not opted to add an xi By converting immediately	test, I opt to convert my xT solid OR After an additional tiss			test if necessary:			MR IHC ER2 IHC + FISH	HRD ¹ Tumor Origin (RNA)	
xT (DNA) & xR (RNA): Solid Tum		ene DNA sequencing test; xR: who			test.			LR1 IHC FDA ²	PurIST™ (RNA, Panc)	
	Requires i	FFPE tissue, blood (EDTA), or bone	marrow aspirate (EDIA).				DN IHC FDA 2	DPYD ¹ on ² UGT1A1 ¹	
Individual testing options								GMT Methylatio /19q FISH ²	on Grial -	
xR (RNA Only): Solid Tumor OF	R Heme Whole tra	nscriptome RNA sequencing test.	Requires FFPE tis	sue, blood (EDTA)), or bone marrow asp	oirate (EDTA).			-resources/ for IHC and FISH tests ordered by cancer	
xT (DNA Only): Solid Tumor OR	P Heme 648-gene	DNA sequencing test. Requires F.	FPE tissue, blood (EDTA), or bone m	narrow aspirate (EDTA).	type, and	d Algorithmic Add-	Ons logistics. 2) Powered by NeoGenomics.	
xF: Liquid Biopsy OR xF+:	Liquid Biopsy xF: 105-g	ene or xF+: 523-gene liquid biops	y test for solid tur	nors. Requires bl	ood (Streck).					
xG(CancerNext®): Hereditary xG+(CancerNext-Expanded®):	OR Hereditary Add +RNAinsigh	t® xG: 36-gene or xG+: 77-ge +RNAinsight®: Supplemen								
•	·					•				
Monitoring Must select ONLY ONE	testing cadence. *Standing orders are for	one year unless # of araws is ina	сатеа.				& specimen re	•		
xM (NeXT Personal® Dx): Minim	Treatment Response Monit	oring (TRM)	and to deather response monitoring (TMT), rest by re			Personalis.				
Date of curative intent surgery:	Single Test	Every 3 Months* Ev	ery 6 Months*	# of Draws:			PE Tissue, blood (I uire: blood (Streck		(Streck).	
D.SPECIMEN RETRIEVAL	See Tempus' specimen guideli	nes for collection instruc	ctions and fu	rther details						
FFPE Tissue / Bone Marrow	Aspirate Submitting pathologist wil	choose FFPE Tissue if spec	imen details ar	e not provided	l.					
Pathology Lab (Name, City)										
Case Number	Date of Collection / Biopsy to be scheduled for			Hospital Outp	•					
					Hospital Inpa	\rightarrow	Not yet dis	scharged OF	P Discharge date:	
Blood / Saliva / Other										
Mobile phlebotomy Send saliva kit to patient Sample previously submitted Patient status at time of specimen collection: Office/Non-Hospital										
Date of Collection: Specimen Collection Facility: Office/Non-Hospital Hospital Outpatient Hospital Inpatient							P Discharge date:			
E.CURRENT DIAGNOSIS										
Breast Colorectal NSC	LC Ovarian Pancreatic	Prostate Other:	Prim	nary ICD-10 C	odes (C, D, & Z co	des):	Stage	e I	II III IV Other:	
Disease Status (select all that apply): Metastatic Refractory	Relapse Recurrent	No Evidend	ce of Disease	Other:		Attach			
Has the patient had any type of transplant? No Yes; Type: Copy of patient's progress notes and/or medical records. Copy of recent pathology report.										
Is the patient currently on or considering immunotherapy? No Yes Unknown; Drug name(s): Copy of insurance card.										
F.BILLING INFORMATION										
Primary insurance plan name	Policy #		Grou	ıp#		Policy Ho	lder Name		Policy Holder DOB	
Patient relationship to policy holder	: Self Spouse Child	Other:			Bill Type: Ins	urance	Hospital/Inst	titution	Self pay/International	
,	•				,po. 1113		. 100p1tuty 11131		pajjanomadona	
G.PROVIDER SIGNATURE		and the search of the search o					f		(2)	
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 and will inform the patient's treatment plan; (3) unless otherwise set forth on this form, the patient has recurrent, relapsed, refractory, metastatic, or advanced stages III or IV cancer; and (4) 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.										

In addition, my signature below certifies that if xT and xF are ordered within 30 days of one another, the order is medically necessary because guidelines support the use of testing, turnaround time for tissue result may delay a treatment decision, 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; and/or genomic heterogeneity may cause available tissue to not be completely representative, and I want to make sure I have a complete mutation profile.

Ordering Provider Signature: Printed Name (full legal name): Today's Date (MM/DD/YYYY): The following fields are for xG (CancerNext®) or xG+ (CancerNext-Expanded®) orders ONLY. Disregard if not testing for hereditary cancers.

H.RELEVANT CLINICAL HISTORY (Previous cancer diagnosis, GI polyps, etc.)

I.FAMILY HISTORY								
None/No known family history Unknown Adopted								
Relationship to patient		Maternal	Paternal	Age at diagnosis	Details of relev	ant history		
				·	,			
J.ANCESTRY						K.BONE MARROW TRAN	SPLANT	
White/Caucasian	Native Am	nerican	Midd	dle Eastern		Personal history of allogeneic bor	e marrow or peripheral stem cell transplant: Yes No	
Hispanic	East Asiar	n	Ashl	kenazi Jewish		Note: Using a blood or saliva sam	ple is not appropriate for patients who have undergone an allogeneic bone	
Black/African American	South Asi	an	Othe	er:		marrow or peripheral stem cell tra		
L.PRIOR PERSONAL OR FA	AMILY HIS	STORY (OF GENE	TIC TESTING				
No personal or family history of molecular and/or genetic testing.						Relationship to patient: Self	Family member:	
Germline testing					Microsatellite instability analysis:			
Test performed: Results:					Stable (MSS) Unstable/High (MSI-High) Unstable/Low (MSI-Low)			
Somatic/tumor testing					Immunohistochemical stainin	g		
Test performed: Results:					Proteins present:	Proteins absent:		