T	Ε	M	P	U	S
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xE Whole Exome Requisition Form 2024.11.06

p: 800.739.4137 | f: 800.893.0276 | e: support@tempus.com

Associated Study	Study ID						

If infor	nation is incomplete o	r missing, test	ing may be de	laved.											
A.PATIENT INFORMATIO		, , , , , , , , , , , , , , , , , , , ,	,	,											
Last Name	*				MI	F	First Name								
DOB (MM/DD/YYYY)	Medical Record #		Biological Se	ex Unknown	Email							Phone			
Address (Street, Unit)				City				State		Postal Code		Country			
B.ORDERING PHYSICIA	N INFORMATION	ı													
Ordering Physician (full legal name	e)												NPI#		
Facility Name			Tempus Account #			E	Email (required for report delivery)				Fax				
Facility Address (Street, Unit)			City				State			Postal Co		ode	Country		
Additional person to be copied						Form com	pleted by								
Name	Email/Fax		Facility Nam	е		Name		Email/Fax		ix			Facility Name		
C.TESTING OPTIONS															
Common test combinations		Test descri	ptions & speci	imen requiren	nents						Optiona	l add-on	testing op	tions	
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.  Requires FFPE tissue w/ normal blood or saliva.  Individual testing options  xR (RNA Only): Solid Tumor Only Whole transcriptome RNA sequencing test. Requires FFPE tissue.								Tissue Based Add-Ons: PD-L1 IHC <sup>1</sup> MMR IHC							
xE (DNA Only): Solid Tumor/N D.SPECIMEN RETRIEVA							. Requires FFPE tissu	ıe w/ norma	al blood or so	aliva.	1) See tempu	us.com/testing	-resources/ for 1	HC tests ordered	by cancer type.
FFPE Tissue Submitting path						ta jartitor	aotano,								
Pathology Lab (Name, City)				ollection Facili				status at t	time of sp	ecimen co	ollection:				
Case Number Block #			Date of Collection / Biopsy to be scheduled for			Hospital Outpatient –					ret discharged <i>OR</i> Discharge date:				
Blood / Saliva															
Mobile phlebotomy Send saliva kit to patient Sample previously submitted  Date of Collection: Specimen Collection Facility:						Patient status at time of specimer Office/Non-Hospital Hospital Outpatient Hospital Inpatient N					collection:  ot yet discharged <i>OR</i> Discharge date:				
E.CURRENT DIAGNOSIS															
Breast Colorectal NS	CLC Ovarian	Pancreatic	Prostate	Other:		Primary I	CD-10 Codes (C,	D, & Z coo	des):		Stage	I	II III	IV (	Other:
Disease Status (select all that app	ly): Metastatic	Refractory	Relapse	Recurrent	No E	idence of D	isease Othe	er:			Attachme				P. 1 1
Has the patient had any type of tra	nsplant? No	Yes; Type:											progress not thology repo		dical records.
Is the patient currently on or cons	idering immunotherapy	/? No	Yes Unkr	nown; Drug na	ame(s):						Сору	of insurance	e card.		
F.BILLING INFORMATIO	N									·					
Primary insurance plan name	Po	olicy #				Group#			Policy Ho	older Nam	ie			Policy Hold	ler DOB
Patient relationship to policy holde	er: Self Spouse	e Child	Other:				Bill Type	e: Insi	urance	Hospita	al/Institu	tion	Self pay/I	nternationa	al
G.PHYSICIAN SIGNATU	RE & CONSENT														
My signature below certifies that (1) the p form, the patient has recurrent, relapsed,															

samples (including genetic material) and health information and perform the ordered test(s); (b) botain, 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.

Today's Date (MM/DD/YYYY): Ordering Physician Signature: Printed Name (full legal name):