	TEMPUS	p: 800.73	39.4137 f: 800	Drm 2025.01.0 D.893.0276 e: sup lete or missing, testi	port@tempus.com			Associat	ted Study				Study	/ ID			
	A.PATIENT INFOR	RMATIO	N														
	Last Name		-				MI		First Nar	ne							
	DOB (MM/DD/YYYY)					known								Phone			
<form> An data principal and all page a</form>	Address (Street, Unit)				(City					State	Postal (Code	Country			
	B.ORDERING PHY	SICIAN	INFORMAT	ION													
	Ordering Physician (full l	egal name)													NPI #		
	Facility Name				Tempus Account #	:			Email (re	equired fo	r report c	lelivery)			Fax		
Name Faculty Name Name Encloy Name Control Name CTESTING OPTIONS ************************************	Facility Address (Street,	Unit)			City			~	1			State	Posta	ll Code	Country		
CIUCIDIA DIANON CONTRACT CONT	Additional person to be	copied						Form co	mpleted	by			1		,		
Common test control large con	Name		Email/Fax		Facility Name			Name				Email/Fax			Facility I	Name	
	C.TESTING OPTIC	ONS				timely pr	ovided. If T	' empus is ur	nable to per	form xT CDx	к, Tempus и	vill reflex to xT LDT. Pl	ease refe	r to the Testing	g Resources	page at tempus.com/testing-	
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et of Draws:Date of curative intent surgery:De not order s ² even if the first set feast is MR0A.DSPECIMEN RETRIEVAL See Tempus' specimen guidelines for collection instructions and further details.FFPE Tissue / Bone Marrow AspirateSubmitting pathologist will choose FFPE Tissue if specimen collection:Office Marrow AspirateSubmitting pathologist will choose FFPE Tissue if specimen collection:Office Marrow AspirateSubmitting pathologist will choose FFPE Tissue if specimen collection:Office Marrow AspiratePatient status at time of specimen collection:Office Mon-HospitalHospital OutpatientNot yet discharge date:Block #Date of Collection / Biopy to be scheduled forOffice Mon-HospitalHospital OutpatientMotige Patient status at time of specimen collection:Office Mon-HospitalMotige Patient Status at time of specimen collection:Office Mon-HospitalHospital OutpatientNot yet discharge date:ColopetialMotige Instruction Facility:Patient status at time of specimen collection:Office Mon-HospitalHospital OutpatientOffice Mon-HospitalHospital OutpatientPatient status at time of specimen collection:Office Mon-Hospital <th co<="" td=""><td>-</td><td></td><td>iths* Every 6</td><td>8</td><td>,</td><td>Every</td><td>6 Month</td><td>s* #ofl</td><td>Draws:</td><td></td><td>Tumor-nai</td><td>ive minimal residual o</td><td>lisease (N</td><td>MRD) assay for</td><td></td><td></td></th>	<td>-</td> <td></td> <td>iths* Every 6</td> <td>8</td> <td>,</td> <td>Every</td> <td>6 Month</td> <td>s* #ofl</td> <td>Draws:</td> <td></td> <td>Tumor-nai</td> <td>ive minimal residual o</td> <td>lisease (N</td> <td>MRD) assay for</td> <td></td> <td></td>	-		iths* Every 6	8	,	Every	6 Month	s* #ofl	Draws:		Tumor-nai	ive minimal residual o	lisease (N	MRD) assay for		
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Pathology Lab (Name, City) Specimen Collection Facility Patient status at time of specimen collection: Office/Non-Hospital Hospital Inpatient Ont yet discharged OR Discharge date: Biood / Saliva / Other Biock # Date of Collection / Biopsy to be scheduled for Patient status at time of specimen collection: Office/Non-Hospital Hospital Inpatient Not yet discharged OR Discharge date: Biood / Saliva / Other Patient status at time of specimen collection: Specimen Collection Facility: Patient status at time of specimen collection: Office/Non-Hospital Hospital Inpatient Not yet discharged OR Discharge date: EccURRENT DIAGNOSIS Breast Colorectal NSCLC Ovarian Pancreatic Prostate Other: Disease Status (select all that apply): Metastatic Refractory Relapse Recurrent No Evidence of Disease Other: Copy of resent pathology report. Copy of resummance and. Patient relationship to policy holder: Self Spouse Child Other: Master patient biologi report. Self Spouse Child Other: Master patient biologi reports. Copy of resummer plan; 03 unless otherwise self of the offeer dets(5); 2(2) the ordered test(5) are medically necessary and will inform the patient's treatment plan; 03 unless otherwise self of the nthe firm, the patient horegained springes and dets the (3) collect and use the saliser's and health information for an indefinite period with applicable law of (0) determine and (0) the determine of and (0) the determine of and (0) the calenthas propode, risks, and benefits of the ordered test(5)	D.SPECIMEN RET	RIEVAL	See Tempus	s' specimen guideli	ines for collection	instruc	tions ar	nd furthe	r details								
Case Number Block # Block # Date of Collection / Biopsy to be scheduled for Hospital Utpatient	FFPE Tissue / Bo	ne Marrow	Aspirate Subm	nitting pathologist wil	l choose FFPE Tissue	e if speci	men deta	ils are no	t provided	l.							
Blood / Saliva / Other Hospital Inpatient Not yet discharge do? Discharge date: Mobile phlebotomy Send saliva kit to patient Sample previously submitted Patient status at time of specimen collection: Office/Non-Hospital Hospital Inpatient Not yet discharged OR Discharge date: Date of Collection: Specimen Collection Facility: Patient status at time of specimen collection: Office/Non-Hospital Hospital Inpatient Not yet discharged OR Discharge date: E.CURRENT DIAGNOSIS Breast Colorectal NSCL Ovarian Pancreatic Prostate Other: Primary ICD-10 Codes (C, D, & Z codes): Stage I II III IV Other: Bisease Status (select all that apply): Metastatic Refractory Relapse Recurrent No Evidence of Disease Other: Copy of nailerin's progress notes and/or medical records. Copy of misurance cand. Copy of Insurance cand.	Pathology Lab (Name, Ci	ty)			Specimen Collectio	on Facilit	ty						collectio	on:			
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Disease Status (select all that apply): Metastatic Refractory Relapse Recurrent No Evidence of Disease Other: Attachments Las the patient had any type of transplant? No Yes; Type: Copy of patient's progress notes and/or medical records. 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 # Group# Policy Holder Name Policy Holder DOB Patient relationship to policy holder: Self Spouse Child Other: Bill Type: Insurance Hospital/Institution Self pay/International Group# Policy Holder Name Policy Holder DOB Policy	E.CURRENT DIAG	NOSIS											,				
Discusse status (select at that apply). Pretabatic Tetapse Te	Breast Colorectal	NSCLC	Ovarian Pa	ancreatic Prostate	Other:		Primary	ICD-10 C	odes (C, I	D, & Z cod	es):		St	age I	II III	IV Other:	
Has the patient had any type of transplant? No Yes; Type: 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 # Group# Policy Holder Name Policy Holder DOB Patient relationship to policy holder: Self Spouse Child Other: Bill Type: Insurance Hospital/Institution Self pay/International Group# Bill Type: Insurance Hospital/Institution Self pay/International 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 received an explanation and perform the ordered test(s); (b) obtain, receive, and receive and share the resulting declaritifies amples and information in carcordance with applicable law; and (d) decidentify such samples and information and use and share the resulting decidentifies amples and information in accordance with applicable law.	Disease Status (select al	l that apply): Metastat	ic Refractory	Relapse Reci	urrent	No Ev	idence of	f Disease	Othe	er:		Att		ent's progres	ss notes and/or medical records.	
F.BILLING INFORMATION Primary insurance plan name Policy # Group# 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 & CONSENT 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 received an explanation and perform the ordered test(s); (b) obtain, receive, and release 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; 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; 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.					Yes Unknown; I	Drug nar	me(s):							Copy of recei	nt pathology		
Primary insurance plan name Policy # Group# 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 & CONSENT 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 received an explanation on 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 received an explanation on definite, receive, 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 results) an necessary for reimbursement or the processing or insurance calina, increave, and (d) de-identify such samples and information and use samples and information 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; and (d) de-identify genomic hedredred rest(s); genomic h	F.BILLING INFOR	MATIO	J			-											
G.PHYSICIAN SIGNATURE & CONSENT 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.				Policy #				Group#				Policy Holder Na	me			Policy Holder DOB	
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 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; 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.	Patient relationship to po	olicy holder	: Self Sj	pouse Child	Other:			I		Bill Type:	: Insu	urance Hospi	ital/Inst	titution	Self pay/	International	
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 amples (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 nay delay 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.	G.PHYSICIAN SIG	GNATUR	E & CONSEI	NT													
Ordering Physician Signature: Printed Name (full legal name): Today's Date (MM/DD/YYYY):	form, the patient has recurren samples (including genetic ma and health information for an In addition, my signature belo	it, relapsed, r aterial) and h indefinite per w certifies th	efractory, metastatio ealth information an iod of time in accorc at if xT and xF are or	c, or advanced stages III d perform the ordered te dance with applicable law rdered within 30 days of c	or IV cancer; and (4) the st(s); (b) obtain, receive, a r; and (d) de-identify such one another, the order is	patient ha and releas h samples medically	as provided se health in and inform necessary	l informed c nformation (nation and u r because gu	onsent that including te use and sha uidelines su	meets the r st results) a re the result pport the us	requiremer as necessar ting de-ider se of testing	nts of applicable law f ry for reimbursement ntified samples and ir g, turnaround time fo	or Tempu or the pro formatio r tissue re	us or its referen ocessing of ins n in accordanc esult may dela	nce lab to: (a surance clair ce with appli y a treatmer	a) collect and use the patient's ms; (c) retain and use samples icable law. nt decision, the tissue is at risk	
	Ordering Physician Signature:				Printed Nam	ie (full legi	al name):						Today's	Date (MM/DD/	(YYYY):		

H.TEMPUS DEFAULT CADENCE DETAILS As used in the Tempus xM clinical validation study. ³ This testing schedule following curative-intent surgery spans two years.							
Curative Intent Procedure	4 weeks (1 month)	12 weeks (3 months)	24 weeks (6 months)	36 week (9 month)	48 weeks (12 months)	72 weeks (18 months)	96 weeks (24 months)
Date of Surgery Blood (2x Streck tubes) Blood (2x Streck tubes							
3) Kotani D, Oki E, Nakamura Y, et al. Molecular residual disease and efficacy of adjuvant chemotherapy in patients with colorectal cancer. Nat Med. 2023;29(1):127-134. doi:https://doi.org/10.1038/s41591-022-02115-4							

The following fields are for xG (CancerNext®) or xG+ (CancerNext-*Expanded*®) orders ONLY. Disregard if not testing for hereditary cancers.

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

J.FAMILY HISTORY None/No known family history Unknown Adopted Relationship to patient Maternal Paternal Age at diagnosis Details of relevant history Image: Colspan="4">Image: Colspan="4" Image: Co

K.ANCESTRY			L.BONE MARROW TRANSPLANT					
White/Caucasian	Native American	Middle Eastern	Personal history of allogeneic bone marrow or peripheral stem cell transplant: Yes No					
Hispanic	East Asian	Ashkenazi Jewish	Note: Using a blood or saliva sample is not appropriate for patients who have undergone an allogeneic bone					
Black/African American	South Asian		marrow or peripheral stem cell transplant.					

M.PRIOR PERSONAL OR FAMILY HISTORY OF GENETIC TESTING						
No personal or family history of m	olecular and/or genetic testing.	Relationship to patient: Self Family member:				
Germline testing Test performed: Results:		Microsatellite instability analysis: Stable (MSS) Unstable/High (MSI-High) Unstable/Low (MSI-Low)				
Somatic/tumor testing Test performed: Results:		Immunohistochemical staining Proteins present: Proteins absent:				