TEMPUS

Requisition Form NYS 2025.01.07

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If information is incomplete or missing, testing may be delayed.

Associated Study	Study ID

A.PATIENT INFORMATION

Last Name	MI	First Name

DOB (MM/DD/YYYY)	Medical Record #	Biological Sex	Email	Phone
		☐ F ☐ M ☐ Unknown		

Address (Street, Unit)	City	State	Postal Code	Country

B.ORDERING PHYSICIAN INFORMATION

Ordering Physician (full legal name)	NPI #

Facility Name	Tempus Account #	Email (required for report delivery)	Fax

Facility Address (Street, Unit)	City	State	Postal Code	Country

Additional person to be copied

Name	Email/Fax

Facility Name

Form completed by

Name	Email/Fax

Facility Name

C.TESTING OPTIONS

† xT CDx will be run for any xT test ordered, when a normal sample is timely provided. If Tempus is unable to perform xT CDx, Tempus will reflex to xT LDT. Please refer to the Testing Resources page at tempus.com/testing-resources/ for xT CDx reflex protocols and xT CDx ordering options.

Test options	Test descriptions	Specimen required	Optional add-on tests (select all that apply):
xT CDx (DNA): ☐ Solid Tumor/Normal	FDA-approved 648-gene DNA sequencing test.	FFPE Tissue; Normal: Blood or Saliva	Tissue Based Add-Ons: ☐ PD-L1 IHC[1] ☐ MMR IHC ☐ HER2 IHC + FISH[1,2] ☐ FOLR1 IHC FDA[2] ☐ CLDN18 IHC FDA[2] ☐ MGMT Methylation[2] ☐ 1p/19q FISH[2]
☐ **Add xF liquid biopsy at time of order.** ☐ **If completion of xT CDx produces a QNS result or identifies no actionable variants, then I elect to add xF and commence testing immediately.**			
xT (DNA): ☐ Solid Tumor† ***OR*** ☐ Heme	648-gene DNA sequencing test.	FFPE Tissue, Blood (EDTA), or Bone Marrow Aspirate (EDTA)	*1. See our Testing Resources website for IHC and FISH tests ordered by cancer type, and Algorithmic Add-On logistics.* *2. Powered by NeoGenomics*
xF (Liquid Biopsy): ☐	105-gene liquid biopsy test for solid tumors.	Blood (Streck)	
xG(CancerNext®)(Hereditary): ☐ ***OR*** xG+(CancerNext-*Expanded*®)(Hereditary): ☐	☐ **Add +RNAinsight®**	xG: 39-gene or xG+: 76-gene hereditary cancer test, powered by Ambry Genetics. *Requires blood (EDTA), saliva, or cultured fibroblast.* +RNAinsight®: Supplemental germline RNA sequencing, powered by Ambry Genetics. *Requires blood (PAXgene® tube required for RNA).*	

D.SPECIMEN RETRIEVAL *See Tempus' specimen guidelines for collection instructions and further details.*

☐ **FFPE Tissue /** ☐ **Bone Marrow Aspirate** *Submitting pathologist will choose FFPE Tissue if specimen details are not provided.*

Pathology Lab (Name, City)	Specimen Collection Facility	Patient status at time of specimen collection:
		☐ Office/Non-Hospital ☐ Hospital Outpatient ☐ Hospital Inpatient → ☐ Not yet discharged ***OR*** Discharge date:

Case Number	Block #	Date of Collection / Biopsy to be scheduled for

☐ **Blood /** ☐ **Saliva /** ☐ **Other**

☐ Mobile phlebotomy ☐ Send saliva kit to patient ☐ Sample previously submitted

Date of Collection: Specimen Collection Facility:

Patient status at time of specimen collection: ☐ Office/Non-Hospital ☐ Hospital Outpatient ☐ Hospital Inpatient → ☐ Not yet discharged ***OR*** Discharge date:

E.CURRENT DIAGNOSIS

☐ Breast ☐ Colorectal ☐ NSCLC ☐ Ovarian ☐ Pancreatic ☐ Prostate ☐ Other:

Primary ICD-10 Codes (C & D codes only):

Stage ☐ I ☐ II ☐ III ☐ IV Other:

Disease Status (select all that apply): ☐ Metastatic ☐ Refractory ☐ Relapse ☐ Recurrent ☐ Other:

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. ☐ 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 (must attach copy of card) ☐ Hospital/Institution ☐ Medicare-Part B ☐ Self pay/International

G.PHYSICIAN SIGNATURE & CONSENT

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

Please *also* complete the required New York State patient consent form. If this form is not completed it may result in order delays.

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 relevant history
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

J.ANCESTRY

☐ White/Caucasian ☐ Native American ☐ Middle Eastern
☐ Hispanic ☐ East Asian ☐ Ashkenazi Jewish
☐ Black/African American ☐ South Asian ☐ Other:

K.BONE MARROW TRANSPLANT

Personal history of allogeneic bone marrow or peripheral stem cell transplant: ☐ Yes ☐ No

Note: Using a blood or saliva sample is not appropriate for patients who have undergone an allogeneic bone marrow or peripheral stem cell transplant.

L.PRIOR PERSONAL OR FAMILY HISTORY OF GENETIC TESTING

☐ No personal or family history of molecular 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:

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