

Molecular Oncology Test Request Form

(For Therapeutical Product)

Please affix here

Barcode-1

PATIENT INFORMATION *(*Indicates a required field)*

*Name:	*Date of Birth <i>(DD/MM/YYYY)</i> :	*Sex at Birth: <input type="checkbox"/> M <input type="checkbox"/> F	*ID(NRIC/Passport No.): <i>**See other information</i>
Medical Record # <i>(optional)</i> :	* Phone No.:	*Country:	
*Address:			

CURRENT DIAGNOSIS & PATIENT HISTORY *(*Indicates a required field)*

Snomed Code	*Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Unknown
*Diagnosis:	
<input type="checkbox"/> NSCLC <input type="checkbox"/> Lung Small Cell Carcinoma <input type="checkbox"/> CRC <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Ovarian Cancer <input type="checkbox"/> Cervical Cancer <input type="checkbox"/> Endometrial Cancer <input type="checkbox"/> Gastric Cancer <input type="checkbox"/> GIST <input type="checkbox"/> Esophageal Cancer <input type="checkbox"/> HCC <input type="checkbox"/> Cholangiocarcinoma <input type="checkbox"/> Pancreatic Cancer <input type="checkbox"/> RCC <input type="checkbox"/> Bladder Cancer <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Adenoid Cystic Carcinoma <input type="checkbox"/> Thyroid Cancer <input type="checkbox"/> Head and Neck Squamous Cell Carcinoma <input type="checkbox"/> NPC <input type="checkbox"/> Melanoma <input type="checkbox"/> Brain tumor <input type="checkbox"/> Neuroendocrine Tumor <input type="checkbox"/> Soft tissue sarcoma <input type="checkbox"/> Occult <input type="checkbox"/> Others _____	
*Prior or Current Treatments:	
<input type="checkbox"/> None <input type="checkbox"/> Targeted Therapy <input type="checkbox"/> Immunotherapy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Combo Therapy	
Attachments:	
Copy of recent pathology/cytology reports, including (if available) CBC/differential, BMA differential, FAB classification. Results from other testing by FISH, IHC, PCR, NGS, or other methodologies (including ER, PR, HER2, EGFR, KRAS, etc.)	
*Has the patient received a transplant?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

TREATING PHYSICIAN INFORMATION *(*Indicates a required field)*

*Name:	MCR:	*Clinic Name:	*Clinic Address/ Postal Code:
*Email:		*Phone No:	
Note:		*Email Report to: <input type="checkbox"/> Clinic <input type="checkbox"/> Others _____ <input type="checkbox"/> Need a hard copy report	

TEST SELECTION *(*Indicates a required field)*

*Test	<input type="checkbox"/> Genecast Focus (41 Genes DNA+RNA)	<input type="checkbox"/> Genecast Comprehensive (769 Genes DNA+RNA)	<input type="checkbox"/> Genecast PARPguide (WGS+HRR Genes)
Variants	SNV/Indel, Fusion, CNV, MSI	SNV/Indel, Fusion, CNV, MSI, TMB	SNV/Indel, BRCA LGR, HRD Status
Acceptable Samples	FFPE Tissue	FFPE Tissue	FFPE Tissue, Blood

PHYSICIAN CERTIFICATION OF MEDICAL NECESSITY AND CONSENT

*(*Indicates a required field)*

My signature below certifies that: (1) I am the treating physician for the patient and possess the legal authority to request the tests listed on this requisition form, (2) each test requested on this form is essential for the patient's medical care, (3) the patient* has chosen to pursue additional cancer treatment, (4) the outcomes of these tests will guide the patient's ongoing treatment strategy, (5) I have discussed the purpose and nature of each test on this requisition with the patient*, who has had the opportunity to ask questions about the tests and the collection, use, and sharing of their samples and data, (6) I have secured informed consent from the patient* using the consent form, authorizing each test and the associated collection, use, and disclosure of their samples and data, (7) I have notified the patient* of their right to obtain a copy of the signed consent form and have filed a signed copy in their medical record. I acknowledge that Genecast may request a copy of the signed consent, and I will provide it upon request.* *(or the patient's legal guardian or representative)*

*Treating Physician Signature:

*Date:

OTHER INFORMATION

For physician: If the patient has changed the passport number since the last time you used a Genecast testing product, please contact us. www.genecast.com.sg