

Specimen Submission Sheet

For Clinic to Fill In *(*Indicates required fields if applicable to test order)*

Clinic Name*:	Physician Name*:
Patient Information*:	Test Ordered*: <input type="checkbox"/> Genecast Focus (41 Genes D+R) <input type="checkbox"/> Genecast Comprehensive (769 Genes D+R) <input type="checkbox"/> Genecast PARPguide (WGS+HRR Genes)

*Specimen Retrieval Type

- Physician is Requesting a Specific Specimen *(add specimen details below)*
 Physician is Requesting the Pathologist to Choose Specimen

FFPE Slides Return Address (optional):

For Tissue Collection to Fill In *(*Indicates required fields if applicable to test order)*

Pathology Lab Name:	*Specimen ID:	*Specimen <i>(biopsy)</i> Site:	
*Date of Collection: <i>(DD/MM/YYYY)</i>	Time of Collection: (24HR) <input type="checkbox"/> No time available	Slide Section/Wax Roll Prepared Date:	
<input type="checkbox"/> Tissue areas larger than 0.5 cm ²		<input type="checkbox"/> Tissue areas smaller than 0.5 cm ²	
≥20% Tumor Cellularity, Specify: _____%	Thickness: _____ μm (≥5μm required)	No. of Slides: _____ slides	No. of Wax Rolls: _____ rolls

Requirements:

- Histopathology Report Attached

Confirm the Following:

- **Genecast Focus / Comprehensive: tumor cellularity ≥20%;**
- **Genecast PARPguide: pre-treatment tissue preferred (tumor cellularity ≥20%), post-treatment tissue ≥50%.**
- For tissue areas ≥ 0.5 cm², provide 4 wax rolls or 10 unstained slides (5–10 μm each).
- For tissue areas < 0.5 cm² or biopsy puncture samples, provide 6 wax rolls or 15 unstained slides (5–10 μm each).
- If tumor cellularity is below 20%, provide 1 H&E-stained slide highlighting a region dense with tumor cells, along with at least 15 unstained slides (5–10 μm each).
- If the number of wax roll or slides does not meet these criteria, please send the existing rolls or slides to Genecast Lab for nucleic acid extraction.

If the cellularity is below 20% and cannot be enriched to 20%, please consult the physician to determine the next steps.

For Blood Collection to Fill In *(*Indicates required fields if applicable to test order)*

Blood Collection Time Point <input type="checkbox"/> Preoperative / Pre-treatment <input type="checkbox"/> Postoperative / Post-treatment	*Blood Collection Volume _____ mL _____ Tube(s)	*Date of Collection: <i>(DD/MM/YYYY)</i> *Time of Collection: <i>(HH:MM)</i>
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Requirements:

- Please provide 1 tube of whole blood, with a volume of no less than 8 mL.
- Please use the designated blood collection tubes provided by Genecast.

Please call Genecast lab if you need any further information. Tel: +65 6047 0252