

Molecular Oncology Test Request Form

Please affix here

Barcode-1

PATIENT INFORMATION *(*Indicates required fields)*

*Name:	*Date of Birth (DD/MM/YYYY):	*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 required fields)*

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 Adenocarcinoma <input type="checkbox"/> Lung Squamous Cell Carcinoma <input type="checkbox"/> Others	<input type="checkbox"/> Colon cancer <input type="checkbox"/> Left-Sided Colon <input type="checkbox"/> Right-Sided Colon <input type="checkbox"/> Rectal Cancer <input type="checkbox"/> HCC <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Soft Tissue Sarcoma <input type="checkbox"/> Occult <input type="checkbox"/> Others
<input type="checkbox"/> Breast Cancer <input type="checkbox"/> ER Positive, PR Positive <input type="checkbox"/> ER Negative, PR Negative <input type="checkbox"/> ER Positive, PR Negative <input type="checkbox"/> ER/PR Unknown	<input type="checkbox"/> Ovarian Cancer <input type="checkbox"/> Endometrial Cancer <input type="checkbox"/> Cervical Cancer <input type="checkbox"/> Melanoma
<input type="checkbox"/> Lung Small Cell Carcinoma <input type="checkbox"/> Esophageal Cancer <input type="checkbox"/> Bladder Cancer <input type="checkbox"/> Head and Neck Squamous Cell Carcinoma <input type="checkbox"/> Neuroendocrine Tumor	<input type="checkbox"/> Gastric Cancer <input type="checkbox"/> GIST <input type="checkbox"/> Pancreatic Cancer <input type="checkbox"/> RCC <input type="checkbox"/> Thyroid Cancer <input type="checkbox"/> NPC <input type="checkbox"/> Brain Tumor

*Prior or Current Treatments:

	None	Targeted Therapy	Immunotherapy	Chemotherapy	Combination Therapy
Neoadjuvant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adjuvant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Systemic Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>				

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?

Yes 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 required fields)*

<input type="checkbox"/> Genecast Focus (41 Genes, Tissue)	<input type="checkbox"/> Genecast Comprehensive (769 Genes, Tissue)	<input type="checkbox"/> Genecast PARP Guide (HRD)
<input type="checkbox"/> Genecast MRD Minerva Prime (Personalized MRD)	<input type="checkbox"/> Genecast ctDNA Comprehensive (769 Genes, Blood)	<input type="checkbox"/> Genecast SarcoFUSE (437 Genes, Sarcoma)
<input type="checkbox"/> Genecast PD-L1 (IHC Test)		

PHYSICIAN CERTIFICATION OF MEDICAL NECESSITY AND CONSENT

*(*Indicates required fields)*

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:
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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.