Genecast

Barcode-2
Please affix here

Specimen Submission Sheet

For Clinic to Fill In *(*Indicates required fields)*

*Clinic Name:	*Physician Name:
*Patient Information:	*Test Ordered: ☐ **Genecast Focus (41 Genes, Tissue)** ☐ **Genecast Comprehensive (769 Genes, Tissue)** ☐ **Genecast ctDNA Comprehensive (769 Genes, Blood)** ☐ **Genecast MRD Minerva Prime (Personalized MRD)** ☐ **Genecast PARP Guide (HRD)** ☐ **Genecast SarcoFUSE (437 Genes, Sarcoma)** ☐ **Genecast PD-L1 (IHC Test)**

***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)*

Pathology Lab Name:	*Specimen ID:	*Specimen *(biopsy)* Site:
*Date of Collection: *(DD/ MM/YYYY)*	Time of Collection: (24HR) ☐ No time available	Slide Section/Wax Roll Prepared Date:

*Tumor Cellularity, Specify: _____%	Thickness: _____μm (≥5μm required)	No. of Slides: _____slides	No. of Wax Rolls: _____rolls

Requirements:

Genecast Product	Tumor Content Requirement	Sample Requirements
Genecast Focus	≥20%	◆ If tumor content meets the requirement: ☐ For tissue areas ≥ 0.5 cm², 4 wax rolls or 10 unstained slides (5–10 μm each). ☐ For tissue areas < 0.5 cm² or biopsy puncture samples, 6 wax rolls or 12 unstained slides (5–10 μm each). ◆ If tumor content does not meet but tumor cells can be enriched (microdissection): ☐ 1 H&E slide marked dense tumor cells region+ 15 unstained slides.
Genecast Comprehensive	≥20%	
Genecast PARP Guide	pre-treatment, preferred, ≥20%, post-treatment tissue ≥50%	
Genecast MRD Minerva Prime	≥20%	
Genecast SarcoFUSE	≥10%	
Genecast PD-L1	≥20%	1 H&E stained slide + 4 unstained sections on positively charged slides.

If the number of wax roll or slides is insufficient, please send the available samples to Genecast Lab for nucleic acid extraction.

If tumor content is insufficient and cannot be enriched, please consult the physician to determine the next steps.

For Blood Collection to Fill In *(*Indicates required fields)*

*** Blood Collection Time Point** ☐ Preoperative / Pre-treatment ☐ Postoperative / Post-treatment	***Blood Collection Volume** _____mL _____Tube(s)	***Date of Collection:** *(DD/ MM/YYYY)* ***Time of Collection:** *(HH:MM)*

Requirements:

- For longitudinal MRD monitoring, please provide 2 tubes of blood; For other, 1 tube is sufficient. Each tube ≥8 mL.
- Please use the designated blood collection tubes provided by Genecast.

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

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