MOLECULAR ONCOLOGY TEST REQUEST

Instructions: Complete all fields marked * and select all applicable options. Information must be legible for clinical laboratory processing.

PATIENT INFORMATION SECTION

(Information must match the patient's NRIC / FIN / Passport)
Patient details may be provided by affixing a patient identification label.

*** Full Name:**		*** ID (NRIC / FIN / Passport):**	
*** Nationality:**	*** Date of Birth:** DD / MM / YYYY	*** Genetic Sex:** M F	Phone No.:
Address:			

CLINICAL DIAGNOSIS & TREATMENT HISTORY

*** Diagnosis:**

NSCLC Lung Adenocarcinoma Lung Squamous Cell Carcinoma Others	Colon cancer Left-Sided Colon Right-Sided Colon	Breast Cancer ER Positive, PR Positive ER Negative, PR Negative ER Positive, PR Negative ER/PR Unknown	Ovarian Cancer	Endometrial Cancer
			_ Head & Neck Squamous Cell Carcinoma	
Lung Small Cell Carcinoma	Rectal Cancer	Cervical Cancer	Gastric Cancer	GIST
Esophageal Cancer	Pancreatic Cancer	Cholangiocarcinoma	HCC	RCC
Bladder Cancer	Prostate Cancer	Adenoid Cystic Carcinoma	Thyroid Cancer	NPC
Neuroendocrine Tumor	Brain Tumor	Melanoma	Soft Tissue Sarcoma	
Occult	Others			

*** Stage:** I II III IV Unknown

***Prior or Current Treatments:**

	None	Targeted Therapy	Immunotherapy	Chemotherapy	Others
Neoadjuvant					_____
Adjuvant					_____
Systemic Therapy					_____

Has the patient undergone surgery?	Yes	No
Has the patient received a transplant?	Yes	No

Attachment(s) provided:

Copy of recent pathology/cytology reports, including 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.)

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TEST SELECTION (please select at least one)

*	Test Type	Testing Coverage	Specimen Type	TAT
☐	**Genecast Focus**	41 Genes	Tissue (FFPE)	**5-7** Working Days
☐	**Genecast Comprehensive**	769 Genes	Tissue (FFPE)	**5-7** Working Days
☐	**Genecast MRD Minerva Prime**	Personalized MRD	Initial Testing: Tissue (FFPE) + Blood (Baseline)	**21** Working Days upon receipt of both blood and tissue
			Follow Up Monitoring: Blood (plasma)	**5-7** Working Days
☐	**Genecast ctDNA Comprehensive**	769 Genes	Blood	**5-7** Working Days
	Select one* ☐ **Somatic Only ☐ **Somatic+Germline**	*Note: For germline reporting:* ***Consent Form – Germline*** *must be completed.*		
☐	**Genecast PARP Guide**	HRD assessment	Tissue (FFPE), Blood	**5-7** Working Days
☐	**Genecast SarcoFUSE**	437 Genes	Tissue (FFPE)	**5-7** Working Days
☐	**Genecast Hereditary Cancer**	87 Genes	Blood	**7-10** Working Days
		*Family History ☐ Yes ☐ No 1. Relationship:_____ Cancer Type:_____ 2. Relationship:_____ Cancer Type:_____		

TREATING PHYSICIAN INFORMATION & DECLARATION

* Physician Name:	MCR:
Email:	Phone:
* Clinic / Hospital Name & Address:	* Report Preference Email Report to: ☐ Clinic ☐ Others ☐ Need a hard copy report
* **PHYSICIAN SIGNATURE:**	* **Date:**

My signature above certifies that:

(1) I am the treating physician for the patient* and possess the legal authority to request the tests specified in 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 are intended to inform and guide the patient's* ongoing treatment and clinical management, (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 obtained informed consent from the patient* using the consent form, authorizing each requested 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 the patient's * medical record. I acknowledge that Genecast may request a copy of the signed consent, and I will provide it upon request.

* Where applicable, references to the patient include the patient's legally authorised guardian or representative.

OTHER INFORMATION

Please contact us if the patient's passport number has changed since their previous Genecast test.

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