CancerVision: Order Form for Whole Genome Sequencing

A. Patient Information

Name (Last, First MI)		Date of birth* (DD/MM/YYYY)	Medical Record #	Sex at Birth	
				☐ Male	☐ Female
Phone (Primary)	Street Address	City	State	Zip	Country
Email		Primary Cancer Diagnosis		Primary ICD-10 Code	

Disease State (check all that apply) ☐ Metastatic ☐ Recurrent ☐ Refractory ☐ Relapse ☐ None ☐ Other

Has the patient had prior genetic testing? ☐ YES ☐ NO If yes, please list test:

B. Treating Physician

Name (Last, First)	NPI#	Address
Office/Practice/Institution	Phone #	Fax #
Email	Contact Name	Contact Phone #
Additional Provider/Report Recipient (Optional) Name (Last, Frist)	NPI#	Address
Email	Phone #	Fax #

C. Specimen Retrieval

Submitting Pathologist Name	Pathology Lab Name	Email	Phone #	Fax #
Pathology Lab Address				

Tumor (FFPE Tissue Sample)

☐ Option 1: Specific specimen requested (Please fill out additional information below) ☐ Option 2: Let the submitting pathologist choose specimen ☐ Option 3: Biopsy to be scheduled for :

Collection Date (MM/DD/YYYY) and Time (AM,PM)	Specimen ID	Site of Biopsy	Alternative Choice (Optional)

Peripheral Whole Blood Date and Time of Blood Collection (MM/DD/YYYY) Time (AM, PM):

D. Certificate of Medical Necessity/Consent/Test Authorization and Physician Signature

By signing below, I certify that (1) I am the treating physician and that this testing is necessary and appropriate for the patient's condition and will be used to inform their treatment plan. I have explained to the patient the purpose, risks and benefits of the test(s) being ordered. (i) the patient (or authorized representative on the patient's behalf) has given his/her informed consent (which includes written informed consent or written authorization when required by law) to have this genetic testing performed, and (ii) the informed consent obtained from the patient meets the requirements of applicable law for Genome Insight or its reference lab to: (a) collect and use the patient's samples (including genetic material) and health information and perform the ordered test(s); (b) obtain, receive, and release health information (including test results) as necessary for reimbursement or the processing of insurance claims; (c) retain and use samples and health information for an indefinite period of time in accordance with applicable law; and (d) de-identify such samples and information and use and share the resulting de-identified samples and information in accordance with applicable law.

Physician Signature:	
Physician Print Name:	Date (MM/DD/YYYY)

E. Billing Information

☐ Insurance (Name/Type)	Policy #	Group #
☐ Self-Pay (Contact Name)	Email	Phone #
☐ Facility (Name)	Address	☐ Same as Treating Physician

F. Specimen Requirements

Tumor (FFPE)
Unstained Slides: 10 from a single tumor, >50 microns total + H&E stained slide for reference*
or
DNA extracted by a CLIA-certified laboratory: 1ug with a minimum concentration of 5ng/uL

Matched normal (whole blood)
Minimum 3 mL EDTA
Clotted or hemolyzed specimens are not accepted
Needs to be <7 days post collection at the time of receipt

*__On the H&E slide, circle the area with the greatest tumor content.__ Failure to follow these instructions will lead to delayed processing of the samples and delayed turnaround time.

The CancerVision Test generally takes 50-100 microns of tissue and the submitted tissue may be exhausted to perform the requested testing.

G. Shipping Instructions

FFPE samples, peripheral blood, and DNA are to be shipped ambient for next day delivery.

Ship samples overnight using the provided FEDEX materials:

ATTN: Accessioning
Genome Insight
6330 Nancy Ridge Drive, Suite 106
San Diego, CA 92121 USA

Please fax or email the completed TRF to:

lab@genomeinsight.net
[858] 260-2207 fax

CLIA # 05D2280195