Oncology

Requisition and Consent Form

Barcode

*All required fields MUST be filled in.

Patient Information			
First Name*		Last Name*	
Date of Birth*	D D / M M / Y Y Y Y	Sex*	☐ M ☐ F
City / State / Country		Primary Ethnicity* (Choose one)	☐ African ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Others
Physician Information			
Clinic/Hospital Name*		Department*	
Name*		E-mail	

* Pease tick(V) the test item for order and check the required sample type.

Cancer Panel Type		Test Item	Sample Type	Collection Date*
Hereditary cancer	☐	Hereditary Breast and Ovarian Cancer panel (BRCA1/BRCA2/TP53)	☐ EDTA WB 3.0 ml	DD/MM/YYYY
	☐	Hereditary Cancer Syndrome Panel		
Hematologic Cancer	☐	Acute Myeloid Leukemia (AML) Panel	☐ EDTA WB 3.0 ml and EDTA BM 3.0 ml	
	☐	Myelodysplastic Syndromes(MDS) / Myeloproliferative Neoplasm(MPN)		
	☐	Acute Lymphoblastic Leukemia (ALL) Panel		
	☐	Lymphoma Panel		
	☐	Multiple Myeloma panel		
	☐	Acute Lymphoblastic Leukemia (ALL) Panel (Tissue)	☐ FFPE 10 Slides, H&E 1 slide ☐ Extracted DNA (3 ug of dsDNA at 40-100 ng/uL)	
	☐	Lymphoma Panel (Tissue)		
	☐	Multiple Myeloma panel (Tissue)		
Solid Cancer	☐	GCG Oncomine Comprehensive Assay Plus (TMB/MSI) ***excl. RNA**	☐ FFPE 10 Slides, H&E 1 slide ☐ Extracted DNA (3 ug of dsDNA at 40-100 ng/uL)	
	☐	GCG Oncomine Comprehensive Assay Plus (TMB/MSI)		
	☐	HRD (Homologous Recombination Deficiency)		
	☐	GCG-Oncomine Pan-Cancer Cell-Free (LBx) Assay ***Advanced cancer (stage III/IV) ONLY.**	☐ Streck cfDNA WB 20 ml	

Diagnosed Cancer Type (MUST choose one)

BRAIN
- ☐ Glioblastoma
- ☐ Other Primary CNS Tumor
- ▸ ____________________

BREAST
- ☐ Breast Carcinoma

GENITOURINARY
- ☐ Bladder Carcinoma
- ☐ Prostate Adenocarcinoma
- ☐ Renal Cell Carcinoma
- ☐ Renal Pelvis Urothelial Carcinoma

GI
- ☐ Appendiceal Adenocarcinoma
- ☐ Cholangiocarcinoma
- ☐ Colorectal Adenocarcinoma
- ☐ Esophageal Adenocarcinoma

GI continued
- ☐ Esophageal Squamous Cell Carcinoma
- ☐ Gastric Adenocarcinoma
- ☐ Gastroesophageal Junction Adenocarcinoma
- ☐ (GIST) Gastrointestinal Stromal Tumor
- ☐ Hepatocellular Carcinoma
- ☐ Pancreatic Ductal Adenocarcinoma
- ☐ Pancreatic Neuroendocrine Tumor
- ☐ Other Gastrointestinal Tumor
- ▸ ____________________

GYNECOLOGIC
- ☐ Cervical Squamous Cell Carcinoma
- ☐ Endometrial Carcinoma
- ☐ Ovarian Carcinoma

HEAD & NECK
- ☐ Head and Neck Carcinoma

LUNG
- ☐ Adenocarcinoma (NSCLC)
- ☐ Large Cell Carcinoma (NSCLC)
- ☐ Squamous Cell Carcinoma (NSCLC)
- ☐ Lung Carcinoid/Neuroendocrine
- ☐ Small Cell Lung Carcinoma
- ☐ Other Lung Tumor
- ▸ ____________________

Please check smoking status
- ☐ Never/Light smoker
- ☐ Heavy smoker (>15 pack-years)

SARCOMA
- ☐ Sarcoma
- ▸ ____________________

SKIN
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Melanoma

THYROID
- ☐ Thyroid Carcinoma

OTHER
- ☐ Carcinoma of unknown primary(CUP)
- ☐ Other
- ▸ ____________________

Stages of Cancer		Current Therapy	

Clinicl history: Please note any relevant previous genetic test results.

Date of Original Diagnosis	D D / M M / Y Y Y Y	Variant Information	(gene, mutation) Ex: EGFR, negative
Additional Comments			

1. I am aware a completed requisition form, and the consent of a physician is required in order to conduct a genetic test.
2. I acknowledge to have received and understood information about the purpose, scope, and limitations of the test.
3. I consent to personal information and specimen being transferred and processed for the performance of the requested test.
4. I understand genetic variants unrelated to the reason of the test may be found, and I wish to be informed of these incidental findings.

☐ Yes

Date	D D / M M / Y Y Y Y	Name of Patient		Signature	

1. I confirm that the patient has given his/her consent for the provision of personal information and specimen for genetic testing.
2. I have explained the purpose, scope, and limitation of the test to the patient and have answered to all of his/her questions regarding the test.

☐ Yes

Date	D D / M M / Y Y Y Y	Name of Physician		Signature	

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