FOUNDATIONONE®CDx FOUNDATIONONE®HEME

APAC Requisition Form

*Required Information

PLEASE SEND COMPLETED FORM TO
FOUNDATION MEDICINE WITHIN THE SPECIMEN KIT

Customer Order Number:

☐ First Submission ☐ Second Submission ☐ Associated Requisition_____ ☐ Associated Study _____

Patient Information

Last Name*	First Name*	
Patient Date of Birth* (MM/DD/YYYY)	Patient Gender* ☐ M ☐ F	Country*
Has the patient had any type of transplant? ☐ Y ☐ N		

Ordering Physician Information

Hospital / Institution / Practice*			
Physician First Name*		Physician Last Name*	
Account #			
Street Address*			
City*			
Phone*	Province	Postal Code*	Country*
		Email Address*	

Pathologist Information

Hospital / Institution / Practice	Submitting Pathologist Name*	
Address*	City*	Postal Code*
Phone*	Email Address*	

Specimen Return Information

Hospital / Institution / Practice	Specimen Return Name	
Address	City	Postal Code
Phone	Email Address	

Additional Physician to be Copied

Name (First Name, Last Name)
Hospital / Institution / Practice*
Email Address

Lab Partner to be Copied [NOT IN REPORT]

Name (First Name, Last Name)
Email Address

Diagnosis Information

☐ Prior FMI Profile? TRF # (if available)

☐ Prior Targeted Therapy?

Profile Ordered* [CHECK THE BOXES ACCORDINGLY]

☐ FoundationOne® CDx (Optimized for solid tumors)	☐ FoundationOne® Heme (Optimized for hematologic malignancies and sarcomas)	☐ PD-L1

☐ Authority given to Foundation Medicine to Change the Profile Selected Above Based on Requisition Form / Pathologist Information

Diagnosis and Specimen Information

Diagnosis*	Stage*	Date of Collection* (MM/DD/YYYY)
Specimen Site*	Specimen I.D.*	ICD Code(s) Listed*

Please Attach the Following

☐ Copy of recent pathology / cytology reports

☐ Results from all other Molecular Diagnostic Assays by FISH, IHC, or other genetic assays, e.g. ER, PR, HER2, EGFR, KRAS, etc.

Comments, Remarks or Special Requests

Order Confirmation and Consent

My signature certifies that I have explained to the patient the nature and purpose of the profiling to be performed and have obtained informed consent, to the extent legally required, to permit FMI to (a) perform the profiling specified herein, (b) retain the results for internal quality assurance/operations purposes, (c) de-identify the profile results and use or disclose such de-identified results for future genomic research.

Physician Signature*

Ordering Physician Signature*	Date (MM/DD/YYYY)

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