Requisition Form

PLEASE SEND COMPLETED FORM TO FOUNDATION MEDICINE

WITHIN THE TISSUE SAMPLE BOX

Time Sensitive - Please Expedite

*Required Information

Patient Information

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

Ordering Physician Information

Hospital / Institution / Practice*			
Ordering Physician*			Account #
Street Address*			
City*	State*	Postal Code*	Country* Hong Kong
Phone*		Fax*	
Email Address* report@hk-mpdc.com			

Tissue diagnosis of cancer established? REQUIRED

☐ Yes	Tumor/Type of diagnosis (provide pathology report)	Stage	☐ Prior FMI Profile? TRF # (if available) ☐ Prior Targeted Therapy?
☐ No	Reason for Profiling. (provide clinic note and/or radiology report or other documentation)		

Additional Physician to be Copied

Name	
Hospital / Institution / Practice*	
Phone	Fax
Email Address	

Additional Physician to be Copied

Name	
Hospital / Institution / Practice*	
Phone	Fax
Email Address	

Certificate of Medical Necessity / Consent

My signature constitutes a Certificate of Medical Necessity and 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 an indefinite period for internal quality assurance/operations purposes, and (c) release the results to the patient's third-party payer as needed for reimbursement purposes.

☑ Does not permit Foundation Medicine to de-identify the profile results and use or disclose such de-identified results for future unspecified research or other purposes.

Comments, Remarks or Special Requests

Physician Signature*

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

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