FOUNDATIONONE® FOUNDATIONONE® Heme

Requisition Form

PLEASE SEND COMPLETED FORM TO FOUNDATION MEDICINE
WITHIN THE TISSUE SAMPLE BOX

*Required Information

☐ 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* Hong Kong

Has the patient had any type of transplant? ☐ Y ☐ N

Customer Order Number:

Ordering Physician Information

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

Pathology Information

Hospital / Institution Name	Submitting Pathologist Name
Phone	Fax
Address (optional)	

Additional Physician to be Copied

Name	
Office / Practice / Facility Name	
Phone	Fax
Email Address	

Test Ordered* (CHECK ONE BOX)

☐ FoundationOne® (Optimized for solid tumors) ☐ FoundationOne® Heme (Optimized for hematologic malignancies and sarcomas)

Full gene lists are availa ble at www.foundationone.com/genelist

Specimen Retrieval

Unless otherwise specified, Foundation Medicine will contact the pathology department indicated above to request your patient's specimen. Please indicate below if you would NOT prefer us to provide this service.

☐ DO NOT contact pathology regarding this case. I will arrange for the specimen to be shipped to Foundation Medicine.

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

Specimen Information

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

Please Attach the Following

☐ Copy of recent pathology / cytology reports

☐ Test 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

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 testing to be performed and have obtained informed consent, to the extent legally required, to permit Foundation Medicine to (a) perform the testing specified herein, (b) retain the test results for an indefinite period for internal quality assurance/operations purposes, (c) de-identify the test results and use or disclose such de-identified for future genomic research, and (d) release the test results to the patient's third-party payer as needed for reimbursement purposes.

Physician Signature*

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

FOUNDATION MEDICINE® Roche

Roche Molecular Information APAC Customer Services Team:
Phone: +65 6880 5399
Email: APAC.foundation@roche.com

Roche is the licensed distributor of Foundation Medicine products outside of the United States.