FOUNDATIONONE® LIQUID CDx FOUNDATIONONE® MONITOR

APAC Requisition Form

Time Sensitive – Please Expedite

*Required Information

PLEASE SEND COMPLETED FORM TO
FOUNDATION MEDICINE WITHIN THE SPECIMEN KIT

Customer Order Number:

Patient Information

Last Name*	First Name*	
Patient Date of Birth* (MM/DD/YYYY)	Patient Gender* ☐M ☐F	Country* Hong Kong
Date of collection/ Blood Draw (MM/DD/YYYY)	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*	State*	Postal Code*	Country* Hong Kong
		Email Address*	

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) FoundationOne® Liquid CDx is not a cancer screening test		

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

Profile Ordered* [CHECK THE BOXES ACCORDINGLY]

☐ **FoundationOne®Liquid CDx** (Liquid biopsy for all solid tumors)	☐ **FoundationOne®Monitor** (Liquid biopsy for all solid tumors)	☐ **PD-L1**

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

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.

Comments, Remarks or Special Requests

Physician Signature*

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

病人曾做器官移植　有 / 否

病人4星期內曾輸血　有 / 否

FOUNDATION MEDICINE® Roche

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