FOUNDATIONONE® LIQUID CDx

APAC Requisition Form

Time Sensitive – Please Expedite

*Required Information

請貼病人標籤

PLEASE SEND COMPLETED FORM TO
FOUNDATION MEDICINE WITHIN THE SPECIMEN KIT

Customer Order Number:

Patient Information

Patient Reference Number (Printed on the Medical Report)

Last Name* | First Name*

Patient Date of Birth* (MM/DD/YYYY) | Patient Gender* ☐ M ☐ F | Country*

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*

Email Address*

Tissue diagnosis of cancer established? [REQUIRED]

☐ Yes | Tumor/Type of diagnosis (provide pathology report) 請填腫瘤/診斷類型 | Stage 請填期別 | ☐ 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)

☐ 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 tobe 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.

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

Comments, Remarks or Special Requests

Physician Signature*

Ordering Physician Signature* 請醫師簽名 | Date (MM/DD/YYYY)

APAC_TRF_FIL_CDx_V2_2

FOUNDATION MEDICINE® | Roche

© 2020 Foundation Medicine, Inc. Foundation Medicine® and FoundationOne® Liquid CDx are registered trademarks. Roche is the licensed distributor of Foundation Medicine products outside of the United States. Version: August 2018.
LIQ-F-002-20181026