TEST REQUISITION FORM

PLEASE ATTACH THE FOLLOWING AND RETURN FAX TO: 667-212-5252 OR EMAIL TO: CUSTOMER SUPPORT@PERSONALGENOME.COM
YOU SHOULD RECEIVE A CONFIRMATION FOR YOUR ORDER. PLEASE CONTACT US IF YOU DO NOT RECEIVE ONE.

◯ **COPY** OF RECENT PATHOLOGY OR 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.	◯ **COPY** OF PATIENT'S INSURANCE CARD, FRONT AND BACK

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI
PATIENT MEDICAL RECORD #	DATE OF BIRTH	GENDER
STREET ADDRESS		APT.#

CITY	STATE	POSTAL CODE	COUNTRY
PHONE# (PRIMARY)			

PATHOLOGY INFORMATION

◯ SEND RESULTS TO PATHOLOGY DEPARTMENT AT THE INSTITUTION LISTED BELOW.

PATHOLOGY DEPARTMENT/INSTITUTION NAME	
NAME	EMAIL
PHONE	FAX

ORDERING PHYSICIAN INFORMATION

OFFICE/PRACTICE/INSTITUTION NAME	
NAME	NPI/ACCOUNT #
STREET ADDRESS	

CITY	STATE	POSTAL CODE	COUNTRY
PHONE	FAX		
EMAIL			

PLEASE INDICATE TESTING TYPE

CANCERSELECT 125 TISSUE TEST	◯ TUMOR ONLY	◯ TUMOR AND NORMAL
PLASMASELECT 64 PLASMA TEST	◯ WHOLE BLOOD	

SPECIMEN RETRIEVAL

Unless otherwise specified, PGDx 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 PGDx.

SPECIMEN INFORMATION (ONLY ONE TEST TYPE PER TRF)

DIAGNOSIS	PRIMARY TUMOR SITE	STAGE	ICD CODE(S) LISTED	DATE OF COLLECTION

SPECIMEN SITE	ACCESSION ID	HISTOLOGY

BILLING INFORMATION (CHECK ALL THAT APPLY)

PATIENT STATUS (must be filled out for Medicare) ◯ NON-HOSPITAL PATIENT ◯ HOSPITAL OUTPATIENT	◯ HOSPITAL INPATIENT	DISCHARGE DATE	INSTITUTION NAME

◯ PRIMARY INSURANCE ◯ SECONDARY INSURANCE ◯ MEDICARE-PART B ◯ HOSPITAL/INSTITUTION ◯ SELF-PAY

PRIMARY INSURANCE	POLICY NUMBER	GROUP NUMBER

INSURED'S NAME (PERSON WHO HOLDS THE POLICY)	INSURED'S DATE OF BIRTH	PATIENT RELATIONSHIP TO INSURED: ◯ SELF ◯ SPOUSE ◯ CHILD ◯ OTHER:

INSURED'S STREET ADDRESS	INSURED'S CITY	STATE	POSTAL CODE

PHYSICIAN SIGNATURE (REQUIRED FOR PGDx TO BEGIN TESTING)

SIGNATURE	DATE SIGNED

PGDx (FOR INTERNAL USE ONLY)

NORMAL	PGDX ID NUMBER	COUNT	INITIALS	SAMPLE TYPE	DATE OF RECEIPT	TEMPERATURE
TUMOR	PGDX ID NUMBER	COUNT	INITIALS	SAMPLE TYPE	DATE OF RECEIPT	TEMPERATURE