

***Required Information**

PLEASE SEND COMPLETED FORM TO
FOUNDATION MEDICINE WITHIN THE SPECIMEN KIT

Customer Order Number:

First Submission Second Submission Associated Requisition _____ Associated Study _____

Patient Information		Ordering Physician Information			
Last Name*		First Name*		Hospital / Institution / Practice*	
Patient Date of Birth* (MM/DD/YYYY)	Patient Gender* <input type="checkbox"/> M <input type="checkbox"/> F	Country*		Physician First Name*	Physician Last Name*
Has the patient had any type of transplant? <input type="checkbox"/> Y <input type="checkbox"/> N		Account #			
		Street Address*			
		City*		Phone*	Province
				Postal Code*	Country*
		Email Address*			

Pathologist Information			Specimen Return Information		
Hospital / Institution / Practice		Submitting Pathologist Name*	Hospital / Institution / Practice		Specimen Return Name
Address*	City*	Postal Code*	Address	City	Postal Code
Phone*	Email Address*		Phone	Email Address	

Additional Physician to be Copied	Lab Partner to be Copied [NOT IN REPORT]	Diagnosis Information
Name (First Name, Last Name)	Name (First Name, Last Name)	<input type="checkbox"/> Prior FMI Profile? TRF # (if available) . <input type="checkbox"/> Prior Targeted Therapy? .
Hospital / Institution / Practice*	Email Address	
Email Address		

Profile Ordered* [CHECK THE BOXES ACCORDINGLY]

<input type="checkbox"/> FoundationOne® CDx <small>(Optimized for solid tumors)</small>	<input type="checkbox"/> FoundationOne® Heme <small>(Optimized for hematologic malignancies and sarcomas)</small>	<input type="checkbox"/> PD-L1
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Authority given to Foundation Medicine to Change the Profile Selected Above Based on Requisition Form / Pathologist Information

Diagnosis and Specimen Information		
Diagnosis*	Stage*	Date of Collection* (MM/DD/YYYY)
Specimen Site*	Specimen I.D.*	ICD Code(s) Listed*

Please Attach the Following	Comments, Remarks or Special Requests
<input type="checkbox"/> Copy of recent pathology / cytology reports <input type="checkbox"/> Results from all other Molecular Diagnostic Assays by FISH, IHC, or other genetic assays, e.g. ER, PR, HER2, EGFR, KRAS, etc.	

Order Confirmation and Consent	Physician Signature*	
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.	Ordering Physician Signature*	Date (MM/DD/YYYY)