FOUNDATIONONE™ | FOUNDATIONONE™ Heme

REQUISITION FORM

PLEASE FAX TO: 1 (617)-418-2290
EMAIL: Client.Services@FoundationMedicine.com

*Required Information

Time Sensetive - Please Expedite

☐ First Submission ☐ Second Submission ☐ Associated Requisition _____ ■ Associated Study _____

Patient Information

Last Name*	First Name*	MI

Patient Medical Record #	Patient DOB*	Patient Gender* ☐M ☐F

Street Address*	Apt. #

City*	State*	Postal Code*	Country
Hong Kong SAR			

Patient Phone # (Primary)*

Has the patient had any type of transplant?

Ordering Physician Information

Office / Practice / Institution Name*
Hong Kong Molecular Pathology Diagnostic Centre

Ordering Physician*	Account #
	202526

Street Address*
27/F, Bonham Trade Centre, 50 Bonham Strand, Sheung Wan

City*	State*	Postal Code*	Country
Hong Kong			

Phone*	Fax*
+852-2986-1272	+852-2527-7028

Email Address*
report@hk-mpdc.com

Pathology Information

Hospital / Institution Name	Submitting Pathologist Name

Phone	Fax

Additional Physician(s) to be Copied

Name

Office/Practice/Facility Name

Phone	Fax

Name

Office/Practice/Facility Name

Phone	Fax

Test Ordered* (CHECK ONE BOX)

☐ **FoundationOne™** (Optimized for solid tumors)

☐ **FoundationOne™ Heme** (Optimized for hematologic malignancies, sarcomas and pediatric cancers)

Full gene lists are available 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

Specimen Information

Diagnosis*	Stage*	Date of Collection*

Specimen Site*	Specimen I.D.*	ICD Code(s) Listed*

Billing Information*

Patient Status** ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Non-hospital patient
**Must be filled out for Medicare

Institution Name*
HK Molecular Pathology Diagnostic Centre

Discharge Date

Bill: ☐ Insurance ☐ Medicare - Part B ☐ Hospital/Institution ☐ Self-Pay (*credit card information required)

Primary Insurance	Name on Credit Card

Policy # Group #	Insured Name	Card Holder Address

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other	Insured DOB	Credit Card #	Exp. Date

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.
- ☐ Front/back copy of insurance card

Comments, Remarks or Special Requests

Bill to Hong Kong Molecular Pathology Diagnostic Centre

Certificate of Medical Necessity/Consent

Your signature constitutes a Certificate of Medical Necessity and a certification that you have obtained the patient's consent for Foundation Medicine's release of the test results to the patient's third party payer when necessary as part of the reimbursement process.

Physician Signature*

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