GC Genome
The Frontier Company in Genomic Diagnostics

Oncology Requisition Form

Barcode

* All reqired fields MUST be filled in.

Patient Information

*First Name		*Last Name	
*Date of Birth	D D / M M / Y Y Y Y	*Sex	□ M □ F
City / State / Country		*Primary Ethnicity (Choose one)	□ African □ Asian □ Caucasian □ Hispanic □ Others

Physician Information

*Clinic/Hospital Name		*Department	
*Name		E-mail	

* Pease tick(V) the test item for order and check the required sample type.

Cancer Panel Type		Test Item	Sample Type	*Collection Date
Hereditary cancer	□	Hereditary Breast and Ovarian Cancer panel (BRCA1/BRCA2/TP53)	□ EDTA WB 3ml □ G-Card(Blood paper)	D D / M M / Y Y Y Y
	□	Hereditary Cancer Syndrome Panel		
Hematologic Cancer	□	Acute Myeloid Leukemia (AML) Panel	□ EDTA WB 3ml and EDTA BM 3ml	
	□	Myelodysplastic Syndromes(MDS) / Myeloproliferative Neoplasm(MPN)		
	□	Acute Lymphoblastic Leukemia (ALL) Panel		
	□	Lymphoma Panel		
	□	Multiple Myeloma panel		
	□	Acute Lymphoblastic Leukemia (ALL) Panel (Tissue)	□ FFPE 10 Slides, H&E 1 slide □ Extracted DNA (3 ug of dsDNA at 40-100 ng/uL)	
	□	Lymphoma Panel (Tissue)		
	□	Multiple Myeloma panel (Tissue)		
Solid Cancer	□	GCG Oncomine Comprehensive Assay Plus (TMB/MSI) *excl. RNA	□ FFPE 10 Slides, H&E 1 slide □ Extracted DNA (3 ug of dsDNA at 40-100 ng/uL)	
	□	GCG Oncomine Comprehensive Assay Plus (TMB/MSI)		
	□	HRD (Homologous Recombination Deficiency)		
	□	GCG-Oncomine Pan-Cancer Cell-Free (LBx) Assay *Advanced cancer (stage III/IV) ONLY.	□ Streck cfDNA WB 20 ml	

Diagnosed Cancer Type (MUST choose one)

BRAIN
- □ Glioblastoma
- □ Other Primary CNS Tumor ▸ _____

BREAST
- □ Breast Carcinoma

GENITOURINARY
- □ Bladder Carcinoma
- □ Prostate Adenocarcinoma
- □ Renal Cell Carcinoma
- □ Renal Pelvis Urothelial Carcinoma

GI
- □ Appendiceal Adenocarcinoma
- □ Cholangiocarcinoma
- □ Colorectal Adenocarcinoma
- □ Esophageal Adenocarcinoma

GI continued
- □ Esophageal Squamous Cell Carcinoma
- □ Gastric Adenocarcinoma
- □ Gastroesophageal Junction Adenocarcinoma
- □ (GIST) Gastrointestinal Stromal Tumor
- □ Hepatocellular Carcinoma
- □ Pancreatic Ductal Adenocarcinoma
- □ Pancreatic Neuroendocrine Tumor
- □ Other Gastrointestinal Tumor ▸ _____

GYNECOLOGIC
- □ Cervical Squamous Cell Carcinoma
- □ Endometrial Carcinoma
- □ Ovarian Carcinoma

HEAD & NECK
- □ Head and Neck Carcinoma

LUNG
- □ Adenocarcinoma (NSCLC)
- □ Large Cell Carcinoma (NSCLC)
- □ Squamous Cell Carcinoma (NSCLC)
- □ Lung Carcinoid/Neuroendocrine
- □ Small Cell Lung Carcinoma
- □ Other Lung Tumor ▸ _____

Please check smoking status
- □ Never/Light smoker
- □ Heavy smoker (>15 pack-years)

SARCOMA
- □ Sarcoma ▸ _____

SKIN
- □ Basal Cell Carcinoma
- □ Squamous Cell Carcinoma
- □ Melanoma

THYROID
- □ Thyroid Carcinoma

OTHER
- □ Carcinoma of unknown primary(CUP)
- □ Other ▸ _____

Stages of Cancer		Current Therapy	

Clinicl history: Please note any relevant previous genetic test results.

Date of Original Diagnosis	D D / M M / Y Y Y Y	Variant Information	(gene, mutation) Ex: EGFR, negative
Additional Comments			

1. I am aware a completed requisition form, and the consent of a physician is required in order to conduct a genetic test.
2. I acknowledge to have received and understood information about the purpose, scope, and limitations of the test.
3. I consent to personal information and specimen being transferred and processed for the performance of the requested test.
4. I understand genetic variants unrelated to the reason of the test may be found, and I wish to be informed of these incidental findings.

□ Yes

Date	D D / M M / Y Y Y Y	Name of Patient		Signature	

1. I confirm that the patient has given his/her consent for the provision of personal information and specimen for genetic testing.
2. I have explained the purpose, scope, and limitation of the test to the patient and have answered to all of his/her questions regarding the test.

□ Yes

Date	D D / M M / Y Y Y Y	Name of Physician		Signature	

CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS

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