TEST REQUISITION FORM

FOUNDATIONACT®

Please fax to: +1 (617) 418-2290
Email: client.services@foundationmedicine.com

*Required Information

☐ Associated Study ID ____________________

For more information or to order online, ***visit www.foundationmedicine.com/genomic-testing/order***

Patient Information

*Last Name ____ *First Name ____ MI ____ *Medical Record # ____ *DOB (MM/DD/YYYY) ____ *Sex ☐ F ☐ M

*Street Address ____ Apt. # ____ *City ____ *State ____ *Postal Code ____ *Country ____ *Phone (primary) ____

Has the patient received prior Foundation Medicine Testing? ☐ N ☐ Y If yes, Associated Requisition # ____________________

Has the patient received any targeted therapies? ☐ N ☐ Y If yes, details: ____________________

Has the patient received any type of transplant? ☐ N ☐ Y If yes, details: ____________________

Diagnosis & Specimen Information

*Diagnosis Established? ☐ N ☐ Y

If no, provide reason for testing: *(FoundationACT is not a screening test)*

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*Diagnosis ____________________

*ICD Code(s) ____________________

*Stage ____________________

*Date of Collection (MM/DD/YYYY) ____________________

Mobile Phlebotomy Requested? ☐ N ☐ Y

For more information on mobile phlebotomy, visit *www.foundationmedicine.com/genomic-testing/order*

Ordering Physician Information

*Facility Name ____ *Ordering Physician Name ____

*Street Address ____________________

*City ____ *State ____ *Postal Code ____ *Country ____

*Phone ____ *Fax ____

*Email ____ *Account # ____

Additional Physician to be Copied:

Facility ____ Name ____

Email ____ Fax ____

Required Attachments

☐ 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.

Billing Information | *Select one of the four payment options and complete all fields indicated*

☐ **Insurance:** Policy # ____ Group # ____ Insurance Name ____
Insured Name ____ ☐ Front/back copy of insurance card attached

☐ **Facility:** ____ Address ____ ☐ Same as ordering physician

☐ **Medicare – Part B:** Policy # ____ Select Patient Status below (*must be filled out for all Medicare):*
☐ Office (non-hospital) ☐ Outpatient ☐ Inpatient: Requires discharge date (MM/DD/YYYY) ____

☐ **Self-Pay:** Contact Name ____ Phone ____ Email ____

Comments

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Certificate of Medical Necessity/Consent

My signature constitutes a Certificate of Medical Necessity and certifies that I have explained to the patient the nature and purpose of the testing to be performed and have obtained informed consent, to the extent legally required, to permit Foundation Medicine to (a) perform the testing specified herein, (b) retain the test results for an indefinite period for internal quality assurance/operations purposes, (c) de-identify the test results and use or disclose such de-identified results for future unspecified research or other purposes, and (d) release the test results to the patient's third-party payer as needed for reimbursement purposes.

Physician Signature

*Ordering Physician Signature ____________________

*Date (MM/DD/YYYY) ____________________