

TEST REQUISITION FORM



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 _____

*ICD Code(s) _____

*Stage _____

*Specimen Site _____

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

Specimen Retrieval | Only one specimen can be tested per order

Foundation Medicine will contact the pathology department (must be indicated below) to request your patient's specimen. *Please select at least one specimen option below.

Preferred Specimen for Testing: Specimen ID _____
Alternate Choice: Specimen ID _____

Pathologist Choice _____

DO NOT contact pathology regarding this case. I will arrange for the specimen to be shipped to Foundation Medicine.

Mobile Phlebotomy requested for FoundationOne®Heme
For more information on mobile phlebotomy, visit www.foundationmedicine.com/genomic-testing/order

Pathology Information

Submitting Pathologist Name _____

Facility _____

Phone _____ Fax _____

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 _____

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.

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 _____

Test Ordered | Select one test

Authority given to Foundation Medicine to change the test selected below based on requisition form/pathology information

FOUNDATIONONE®
For solid tumors

FOUNDATIONONE®HEME
For hematologic malignancies and sarcomas

Additional Options:

IHC Testing: PD-L1

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.



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