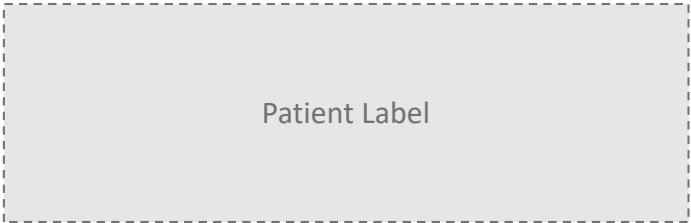


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*** Required Information**

Completed by ACT Genomics

Submission Date (MMM dd, yyyy): <i>(e.g. JAN 31, 2019)</i>	Project ID:	Requisition Number:
---------------------------------------------------------------	-------------	---------------------

Patient Information		
*Last Name	*First Name	Middle
*DOB (MMM dd, yyyy) <i>(e.g. JAN 31, 2019)</i>	*Gender	Ethnicity
*Patient Medical Record #	*Diagnosis	*Stage
* Has the patient received a transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Ordering Physician Information		
*Institution Name		
*Last Name	*First Name	Middle
*Address		
Phone	Fax	
Email		

Pathology Information	* Submitting Hospital	* Specimen #	* Specimen Site
	Submitting Pathologist Name		

* Test Ordered	* Specimen Information
<input type="checkbox"/> ACTOnco® + (440 genes) <input type="checkbox"/> ACTDrug® + (40 genes) <input type="checkbox"/> ACTFusion™ (31 genes) <input type="checkbox"/> MSI Phenotype Assay™	<input type="checkbox"/> FFPE sample, Collection date (MMM dd, yyyy): _____ <input type="checkbox"/> Tissue <input type="checkbox"/> Cell <input type="checkbox"/> _____ slides† <input type="checkbox"/> _____ rolls† <input type="checkbox"/> _____ blocks <input type="checkbox"/> H&E stain, _____ slides
<input type="checkbox"/> ACTMonitor®+ (50 genes) <input type="checkbox"/> ACTMonitor® Breast (8 genes) <input type="checkbox"/> ACTMonitor® Lung (11 genes) <input type="checkbox"/> ACTMonitor® Colon (13 genes)	<input type="checkbox"/> Whole blood (≥ 8 ml) or <input type="checkbox"/> CSF (≥ 8 ml) Collection date(MMM dd, yyyy): _____
<input type="checkbox"/> ACTRisk™ (32 genes) <input type="checkbox"/> ACT Associate Assay™	<input type="checkbox"/> Whole blood (≥ 8 ml) Collection date(MMM dd, yyyy): _____
<input type="checkbox"/> ACTBRCA® [FFPE only] (BRCA1/2) <input type="checkbox"/> ACTBRCA® [Blood only] (BRCA1/2 & LGR) <input type="checkbox"/> ACTBRCA® [FFPE + blood] (BRCA1/2 & LGR) <input type="checkbox"/> ACTBRCA® HRD [FFPE + blood] (48 genes & LGR (BRCA1/2))	<input type="checkbox"/> FFPE sample, Collection date (MMM dd, yyyy): _____ <input type="checkbox"/> Tissue <input type="checkbox"/> Cell <input type="checkbox"/> _____ slides† <input type="checkbox"/> _____ rolls† <input type="checkbox"/> _____ blocks <input type="checkbox"/> H&E stain, _____ slides <input type="checkbox"/> Whole blood (≥ 8 ml), Collection date (MMM dd, yyyy): _____ <input type="checkbox"/> Pending for FFPE sample <input type="checkbox"/> Pending for whole blood sample

(† Please provide 5-20 unstained FFPE sections at 10-µm-thick. The total surface area of the sections combined should be ≥ 125 mm²)

Additional Requests (please provide if available)	
<input type="checkbox"/> Molecular diagnostic results by IHC, FISH or other genetic assays, e.g. HER2, EGFR and KRAS, etc. <input type="checkbox"/> Previous treatment, please specify:	<input type="checkbox"/> Copy of pathology report(s) <input type="checkbox"/> Request for specimen to be returned

*Physician Signature	
<input type="checkbox"/> I declare that the above information provided are accurate. <input type="checkbox"/> I declare that the specimen does not contain pathogens or infectious agents such as hepatitis B, hepatitis C, HIV-I or HIV-II.	Ordering Physician Signature/ Date (MMM dd, yyyy) _____

Specimen and Order Receiving (Completed by ACT Genomics)	
<input type="checkbox"/> All samples and documents listed above were received. If not, please specify:	Recipient Signature/ Date (MMM dd, yyyy) _____