CLINICAL REQUISITION FORM (HK)

Taipei Laboratory:
3F., No.345, Xinhu 2nd Rd., Neihu Dist., Taipei City 114, Taiwan (R.O.C.)
Tel: +886 2 2795 3660 Fax: +886 2 2795 5016
Email: sample@actgenomics.com

Hong Kong Office:
Tel: +852 3162 3038
Fax: +852 3162 3037

Patient Label

*Required Information

Completed by ACT Genomics

Submission Date (MMM dd, yyyy): *(e.g. JAN 31, 2019)*	Project ID:	Requisition Number:

Patient Information

*Last Name	*First Name	Middle
*DOB (MMM dd, yyyy) *(e.g. JAN 31, 2019)*	*Gender	Ethnicity
*Patient Medical Record #	*Diagnosis	*Stage
*Has the patient received a transplant? ☐Yes ☐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 Type
☐ **ACTOnco®+** ☐ **ACTDrug®+** ☐ **ACTLung™**	☐ **ACTFusion™** ☐ **ACTHRD™** ☐ **ACTBRCA® [Tissue]**	☐ **FFPE sample**, Collection date (MMM dd, yyyy):_____ ☐ Tissue ☐ Cell Block ☐ _____slides† ☐ _____rolls† ☐ _____blocks ☐ H&E stain, _____slides
☐ **ACTCerebra™**		☐ **CSF** (≥ 8 ml) [please use Streck or Roche IVD tube] Collection date(MMM dd, yyyy):_____
☐ **ACTMonitor® +** ☐ **ACTMonitor® Lung**	☐ **ACTMonitor® Breast** ☐ **ACTMonitor® Colon**	☐ **Whole blood** (≥ 8 ml) [please use Streck or Roche IVD tube] Collection date(MMM dd, yyyy):_____
☐ **ACTBRCA® [Blood]**	☐ **ACTRisk™**	☐ **Whole blood** (≥ 8 ml) [please use EDTA tube] Collection date(MMM dd, yyyy):_____

1.† Please provide 5-20 unstained FFPE sections at 5 µm-thick. The total surface area of the sections combined should be ≥ 125 mm²)
2. The essential tumor purity for each test are listed at below, we will reject the specimen without enough tumor purity
Tumor purity requirement: ACTDrug®+, ACTFusion™ & ACTLung™: ≥ 10%; ACTOnco®+ & ACTHRD™ & ACTBRCA®[Tissue]: ≥ 30%

Special Requests or Remark

☐ Molecular diagnostic results by IHC, FISH or other genetic assays, e.g. HER2, EGFR and KRAS, etc. ☐ Copy of pathology report(s)

☐ Previous treatment, please specify: ☐ The specimen has to be returned

*Physician Signature

☐ I declare that the above information provided is accurate.

☐ I declare that the specimen does not contain pathogens or infectious agents such as hepatitis B, hepatitis C, HIV-I or HIV-II.

To Department of Pathology:*_____*(Hospital) ***Lab report no:*_____**

The patient is planning to have the above test from the previous biopsied tissue to search for treatment options. Please prepare the specimen for ACT Genomics to collect

Ordering Physician Signature/ Date (MMM dd, yyyy) _____

Specimen and Order Receiving (Completed by ACT Genomics)

☐ All samples and documents listed above were received. If not, please specify:	**Recipient Signature/ Date (MMM dd, yyyy)**

**Please make a copy for your reference