CLINICAL REQUISITION FORM (SEA)

Taipei Laboratory:
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Patient Label

* Required Information

Patient Information		
*Last Name	*First Name	Middle
*DOB (MMM dd, yyyy) *(e.g. JAN 31, 2019)*	*Gender	Ethnicity
*Patient Medical Record #	* Has the patient received a transplant? ☐Yes ☐No	
*Diagnosis (Please indicate it **specifically**) *(e.g. Breast Cancer, TNBC/ luminal A/ luminal B… subtype)* *(e.g. NSCLC, Adenocarcinoma/ squamous cell carcinoma… subtype)*		*Stage

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
☐ **ACTOnco® +** ☐ **ACTDrug® +** ☐ **ACTFusion™** ☐ **ACTLung™** ☐ **MSI Phenotype Assay™**	☐ **ACTHRD™** ☐ **ACTHRR™** ☐ **BRCA/ATM NGS Assay** ☐ **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** (2 tubes & ≥ 8 ml/tube) [please use Streck or Roche IVD tube] Collection date(MMM dd, yyyy):_____
☐ **ACTBRCA® [Blood]** ☐ **MLPA BRCA1 Assay** ☐ **MLPA BRCA2 Assay**	☐ **ACTRisk™** ☐ **ACT Associate Assay™**	☐ **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 tumour content of the sample for each ACT Genomics services varies; preferably need ≥30%. Samples not meeting the required tumour cellularity/content will be rejected.

Additional document(s) provided to ACT Genomics / Request for specimen return	
☐ 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:	☐ Request for specimen to be returned

*Specimen's Declaration	
☐ I declare that the above information provided are accurate. ☐ 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)** _____

Please tick ☑ on the relevant boxes.

**Please make a copy for your reference