CANCER GENETICS INCORPORATED
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CGI's Diagnostic Center of Excellence appreciates feedback from both physicians and patients, as we carefully consider their voices and integrate them in the development and enhancement of our services.
Email: YourInput@cgix.com

Liquid::*cfDNA* Requisition

CGI LAB USE ONLY
Accession # _____
Date: _____ Time: _____

Patient Information

Patient Name (Last, First): _____
Date of Birth (MM/DD/YY): _____ /_____ /_____ Age: _____ Sex: ☐ Male ☐ Female
Social Security #: _____ Medical Record #: _____
Patient Address: _____
_____

Patient Clinical Data

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American
☐ Eastern European ☐ Western European ☐ Northern European ☐ Jewish (Ashkenazi)
☐ Pacific Islander ☐ Middle Eastern ☐ Other: _____

Institution Information

Facility Name: _____
Address:
Phone: _____ Ext _____ Fax: _____
Ordering Physician (please print): _____ Tel.#: _____
Referring Physician (please print): _____ Tel.#: _____
Requisition completed by: _____ Date: _____

Specimen Information

Location Name: _____ Specimen ID #: _____
Phone: _____ Fax: _____
Collection Date (MM/DD/YY): _____ /_____ /_____ Collection Time: _____ ☐ AM ☐ PM
Specimen Type: ☐ Peripheral Blood (cfDNA blood collection tubes)

Coding Information

Diagnosis Code/ICD-10 Code (required):
_____
The physician is required to document all applicable ICD-10 codes or narrative descriptions for all tests ordered supporting medical necessity which shall be used in patient plan of care.

Billing Information

Required: Please attach face sheet and front/back of patient insurance/Medicare card.

☐ Medicare Billing (U.S. Only)

☐ I have attached a copy of the patient's Medicare card & requirements (criteria checklist, patient consent, LMN; available at www.cancergenetics.com)
Medical ID #: _____ Medicare is: ☐ Primary payer ☐ Secondary payer
☐ The patient has been treated as a hospital inpatient (>24 hour stay) in the last 14 days

☐ Insurance Billing (U.S. Only)

☐ I have attached a copy of the patient's card
Insurance Company Name: _____ Member ID #: _____
Patient Relation to Policy Holder: ☐ Self ☐ Child ☐ Spouse ☐ Other
Policy Holder Name: _____

☐ Institutional Billing

☐ Send invoice to practice address above
Billing Contact Name: _____ Phone: _____
Billing Email: _____ Fax: _____
Billing Address: _____ City: _____
State: _____ Zip Code: _____ Country: _____

☐ Patient Pay Billing

CGI will send an electronic invoice to the patient email listed above

☐ Other Billing

CGI Study Code: _____

Clinical Information / Patient History

Brief Clinical History:

☐ Primary tumor site: _____
☐ Diagnosis: _____
☐ Disease stage: ☐ Stage I – II ☐ Stage III ☐ Stage IV ☐ Unknown
☐ Prior molecular testing:
- ☐ Specimen type: ☐ FFPE tissue bx ☐ FFPE FNA/cytology ☐ Peripheral blood ☐ Other: _____
- ☐ Test date: _____ /_____ /_____
- ☐ Test findings/mutation detected:

☐ Treatment status/reason for cfDNA testing:
- ☐ Pretreatment
- ☐ Tissue bx was not performed/QNS/inconclusive
- ☐ Post treatment monitoring
- ☐ Other: _____

☐ Please indicate treatment plan (check all that apply):
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ Targeted therapy
- ☐ Immunotherapy
- ☐ Other: _____

☐ Please attach the following:
- ☐ Clinical history and/or most recent Oncologist's progress note
- ☐ Pathology report(s)
- ☐ Radiology/imaging study report(s)
- ☐ Previous molecular test results

Testing Services

☑ **Liquid::Lung-*cfDNA*™ NGS Panel**

☐ **More than 150 hotspots mutation detection in 11 genes including: *ALK*** (Exon 21-25), ***BRAF*** (V600E), ***EGFR*** (T790M, C797S, L858R, Exon 19 del), ***ERBB2***, ***KRAS*** (codons 12, 13, 61), ***MAP2K1, MET, NRAS, PIK3CA*** (E545K, H1047R, E542K), ***ROS1, TP53***.

The undersigned certifies that he/she is licensed to order the test(s) listed above and that such test(s) are medically necessary for the care/treatment of this patient.

Physician's Signature: _____ Date: _____

SPECIMEN REQUIREMENTS AND COLLECTION INSTRUCTIONS

- Label the collection tubes with the patient's information including name, date & time of blood draw, and date of birth.
- Collect approximately 10 - 20 ml of peripheral blood using the enclosed cfDNA blood collection tubes.
- Gently invert the blood tubes 7-10 times to mix the blood with the DNA stabilizer.
- Place blood tube in the white foam insert and then in the biohazard bag.
- Place biohazard bag into the transportation kit.
- Ship kit at room temperature to Cancer Genetics using the enclosed preprinted air bill.