



### PATIENT INFORMATION

Last Name	First Name	MI
Date of Birth / /	Biological Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Telephone	Email	
Address		
City / State / Zip		
Ethnicity (Check all that apply)		
<input type="checkbox"/> African American	<input type="checkbox"/> Ashkenazi Jewish	<input type="checkbox"/> Asian
<input type="checkbox"/> Middle Eastern	<input type="checkbox"/> Native American	<input type="checkbox"/> Pacific Islander
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Other
<input type="checkbox"/> Unknown		

### REFERRING PROVIDER INFORMATION

Name	Additional Clinician
NPI#	Clinic / Institution
Address	Telephone
Email	Fax
Sending Physician Practice:	
<input type="checkbox"/> Doctor's Office <input type="checkbox"/> Referral Lab <input type="checkbox"/> Hospital - Inpatient <input type="checkbox"/> Hospital - Outpatient	

**MEDICAL PROVIDER SIGNATURE OF MEDICAL NECESSITY REQUIRED BELOW:** I certify the medical necessity of the laboratory test(s) requested and that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the test(s). I have answered this person's questions and obtained informed consent from the patient or their legal guardian for this testing, to the extent required by law.

SIGNATURE \_\_\_\_\_ DATE (MM/DD/YY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### BILLING INFORMATION

INSURANCE - Include a copy of both sides of primary and secondary insurance card(s)

Policyholder Last Name	Policyholder First Name
Policyholder DOB / /	
Insurance Carrier	
Insurance ID	Group No.
Billing Address	
Secondary Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	
Secondary Insurance Name	Group No.
SELF-PAY: <input type="checkbox"/> Credit Card <input type="checkbox"/> Check	
Make Checks Payable to: Sema4 Genomics, P.O. Box 21312, New York, NY 10087-1312	

### CLINICAL INDICATIONS/PATHOLOGY

Type of Cancer	Stage of Cancer
Specimen Information (Include any pathology reports)	
Collection Date: ____ / ____ / ____	Collection Time: ____ : ____ <input type="checkbox"/> AM <input type="checkbox"/> PM
# of Specimens sent: Lavender ____ Yellow ____ Green ____	
Paraffin Block* ____ Slides - Unstained ____ Stained ____ gDNA/RNA ____	
*Anatomic site/Collection Method: _____	

### BLOCK ID \_\_\_\_\_

### PATIENT HISTORY

**ICD Dx CODE(S)** The ICD-10-CM codes listed here are for reference only; practitioners should select ICD-10-CM code(s) based on the patient's condition as of the date of service, even if such code(s) are not listed below.

<input type="checkbox"/> C43.9 Malignant melanoma of skin, unspecified	<input type="checkbox"/> C18.9 Malignant neoplasm of colon, unspecified
<input type="checkbox"/> C50.919 Malignant neoplasm of unspecified site of unspecified female breast	<input type="checkbox"/> C34.90 Malignant neoplasm of unspecified part of unspecified bronchus or lung
<input type="checkbox"/> C71.9 Malignant neoplasm of brain, unspecified	<input type="checkbox"/> C80.1 Malignant (primary) neoplasm, unspecified
<input type="checkbox"/> C73 Malignant neoplasm of thyroid gland	
Other: _____	

**ASSIGNMENT AND RELEASE:** I hereby authorize my insurance benefits be paid directly to the provider and I understand that I am financially responsible for uncovered services. I also authorize the release of any information required to process the claim. Billing inquiries, please call 800-298-6470.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Testing History  
 No prior molecular testing  
 Patient has had prior molecular testing (attach results)

Family History of Cancer  
 None  Yes (complete below)

Relation to patient	H/o cancer	Dx age
<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal <input type="checkbox"/> Other		
<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal <input type="checkbox"/> Other		

### LABORATORY TEST ORDERED

Sema4 Solid Tumor Panel

161 of the most relevant cancer driver genes for clinically significant mutations (See Reverse for Full Gene Listing).

### Lab Use Only

TEMP	SPECIMEN	# OF SPEC	TEMP	SPECIMEN	# OF SPEC	DATE SPECIMEN RECEIVED	INITIALS
Am Ref Fz			Am Ref Fz			/ /	

Client Bill    Institutional Bill

REV. 0318

**GENE LISTING**

All Coding Exons Sequenced (48 genes)	HotSpot Regions Sequenced (87 genes)	Rearrangements/Fusions Queried (51 genes)	Copy Number Variations Queried (43 genes)
<p><i>ARID1A, ATM, ATR, ATRX, BAP1, BRCA1, BRCA2, CDK12, CDKN1B, CDKN2A, CDKN2B, CHEK1, CREBBP, FANCA, FANCD2, FANCI, FBXW7, MLH1, MRE11, MSH2, MSH6, NBN, NF1, NF2, NOTCH1, NOTCH2, NOTCH3, PALB2, PIK3R1, PMS2, POLE, PTCH1, PTEN, RAD50, RAD51, RAD51B, RAD51C, RAD51D, RB1, RNF43, SETD2, SLX4, SMARCA4, SMARCB1, STK11, TP53, TSC1, TSC2</i></p>	<p><i>AKT1, AKT2, AKT3, ALK, AR, ARAF, AXL, BRAF, BTK, CBL, CCND1, CDK4, CDK6, CHEK2, CSF1R, CTNNB1, DDR2, EGFR, ERBB2, ERBB3, ERBB4, ERCC2, ESR1, EZH2, FGFR1, FGFR2, FGFR3, FGFR4, FLT3, FOXL2, GATA2, GNA11, GNAQ, GNAS, H3F3A, HIST1H3B, HNF1A, HRAS, IDH1, IDH2, JAK1, JAK2, JAK3, KDR, KIT, KNSTRN, KRAS, MAGOH, MAP2K1, MAP2K2, MAP2K4, MAPK1, MAX, MDM4, MED12, MET, MTOR, MYC, MYCN, MYD88, NFE2L2, NRAS, NTRK1, NTRK2, NTRK3, PDGFRA, PDGFRB, PIK3CA, PIK3CB, PPP2R1A, PTPN11, RAC1, RAF1, RET, RHEB, RHOA, ROS1, SF3B1, SMAD4, SMO, SPOP, SRC, STAT3, TERT, TOP1, U2AF1, XPO1</i></p>	<p><i>AKT2, ALK, AR, AXL, BRAF, BRCA1, BRCA2, CDKN2A, EGFR, ERBB2, ERBB4, ERG, ESR1, ETV1, ETV4, ETV5, FGFR1, FGFR2, FGFR3, FGR, FLT3, JAK2, KRAS, MDM4, MET, MYB, MYBL1, NF1, NOTCH1, NOTCH4, NRG1, NTRK1, NTRK2, NTRK3, NUTM1, PDGFRA, PDGFRB, PIK3CA, PPARG, PRKACA, PRKACB, PTEN, RAD51B, RAF1, RB1, RELA, RET, ROS1, RSPO2, RSPO3, TERT</i></p>	<p><i>AKT1, AKT2, AKT3, ALK, AR, AXL, BRAF, CCND1, CCND2, CCND3, CCNE1, CDK2, CDK4, CDK6, EGFR, ERBB2, ESR1, FGF19, FGF3, FGFR1, FGFR2, FGFR3, FGFR4, FLT3, IGF1R, KIT, KRAS, MDM2, MDM4, MET, MYC, MYCL, MYCN, NTRK1, NTRK2, NTRK3, PDGFRA, PDGFRB, PIK3CA, PIK3CB, PPARG, RICTOR, TERT</i></p>