HELICE
GENOMIC SCIENCES, INC.

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Received on (MMDDYYYY): _____

☐ Call ☐ Email Your Accession # _____

SOLID TUMOR GENETIC PROFILING REQUISITION FORM

PATIENT INFORMATION

Last Name	First Name	MI

Date of Birth	Gender ☐ M ☐ F	Email Address

Address	Home Number / Mobile Number

Today's Date	Collection Date

Ethnicity ☐ African American ☐ Ashkenazi ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other (please specify) _____

REFERRING PHYSICIAN INFORMATION

Physician's Name:

License Number:

Specialty:

Affiliated Hospital:

Address:

Contact Number:

Email Address:

SEND REPORT TO

SERVICE MENU

01 ☐ **OncoGxOne™** (64 gene panel for solid tumors)	03 ☐ **OncoGxSelect™** (12 gene panel: ALK, BRAF, EGFR, ERBB2, KIT, KRAS, MAP2K1, MET, NRAS, PIK3CA, RET, ROS1)
02 ☐ **OncoGxOne™ Plus** (>360 gene panel)	04 ☐ Include **PGxOne™ Plus** (blood sample required)

CLINICAL INFORMATION (Attach clinical notes and current medication list)

CIRCLE ALL DIAGNOSIS CODES THAT APPLY (USE ADDITIONAL BLANKS IF NEEDED)

Lung and Bronchial Cancer
❑ C34.90

Melanoma
❑ C43.9

Thyroid Cancer
❑ C73

Head, Face and Neck Cancer
❑ C76.0

Brain Cancer
❑ C71.9

Thymic Cancer
❑ C37

Leukemia
❑ C95.9

CML Not in Remission
❑ C92.10

CML in Remission
❑ C92.11

Breast Cancer
❑ C50.919

Endometrial Cancer
❑ C54.1

Ovarian Cancer
❑ C56.9

Cervical Cancer
❑ C53.9

Bladder Cancer
❑ C67.9

Kidney Cancer, except renal pelvis
❑ C64.9

Renal Pelvis Cancer
❑ C65.9

Neuroblastoma
❑ C74.90

Hepatoma Cancer
❑ C22.00

Colon Cancer
❑ C18.9

Rectal Cancer
❑ C20

Gastric Cancer
❑ C16.9

Esophageal Cancer
❑ C15.9

Pancreatic Cancer
❑ C25.9

Prostate Cancer
❑ C61

Liposarcoma
❑ C49.9

Other ICD10 Code _____

Other ICD10 Code _____

Other ICD10 Code _____

SPECIMEN INFORMATION

Diagnosis	Stage
Primary Tumor Site (if known)	Specimen Site
Specimen I.D.	Histology

☐ FFPE Slides ☐ Tissue Block ☐ Blood

(For reflex to PGxOne™ Plus or as normal control,collect in EDTA-coated purple top vacutainer)

Pre-Treatment
☐ Surgery ☐ Chemo ☐ Radiation ☐ Targeted Therapy ☐ Others _____

PLEASE ATTACH THE FOLLOWING

❑ Copy of recent pathology/cytology reports and clinical notes
❑ Test results from all other Diagnostic Assays including, but not limited to, FISH, IHC, PCR,microarray for ER, PR, HER2, EGFR, ALK, etc.
❑ Front/back copy of insurance card

X _____

Signature over Printed Name

❑ **I confirm documented medical necessity for this test in the patient's file.**

NOTES