## Oncotype DX® Requisition Form

Senomic Health oncotype DX

| Customer Service Contact Information | Fax | Fax | Canada (866) ONCOTYPE (866) 662 6897 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 650 569 20 | 1 65 +1 650 569 2080

| SECTION I. SUBMISSION STATUS   |  |  |  |  |  |  |
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| RESUBMISSION — Original Requisition No. STUDY NAME / CODE  |  |  |  |  |  |  |
| SECTION II. ASSAY & SPECIMEN CRITERIA  |  |  |  |  |  |  |
| 0  |  |  |  |  |  |  |
|  | ivasive Breast Canc  |  | Onco <i>type</i> DX Colon Cancer Assay   |  |  |  |
| DCIS Score <sup>TM</sup>   | er   | Important: Stage (AJCC 6th ed.) and Assay selection determines the results presented on the report.  |  |  |  |  |
| for Ductal Carcinoma In Situ Patient for Inva  | sive Breast Cancer Pat   | r Patient Stage II Patien  |  | t I  | Stage III A/B Patient  |  |
| (no invasive cancer present) ER STATUS:  | *NODE S  |  | (T3 or T4) AND Node Negative   |  | Any T AND 1-3 Positive Nodes   |  |
| Positive   | Positive   |  | Sequential Assays:   |  | Onco <i>type</i> DX Colon Cancer   |  |
| Negativ  | ☐ Negative ☐ Mid   |  | MMR then Onco <i>type</i> DX Colon Cancer  if MMR Proficient  oncotype DX Colon Cancer  and MMR Assays   |  | and MMR Assays   |  |
|  | pN1m   | ii (0.2-2.0mm)   |  | par Assou  |  |  |
|  |  | itive 1-3  | Onco type DX Colon Can<br>(for known MMR Proficient tur  | nors)  | Onco <i>type</i> DX Colon Cancer Assay   |  |
| Unknow   | n Posi   | tive 4+  |  | ı  |  |  |
| SECTION III. ORDERING PHYSICIAN  | ADD  | ITIONAL PH   | IYSICIAN (Optional)  |  | PATHOLOGY CO.  |  |
| LAST NAME Sens : Hb  | LAST NAME  |  | (opinional)  | LAST NAME  | PATHOLOGY (Optional)   |  |
| FIRST NAME   | - CIDOT HAME   |  |  |  |  |  |
| John   |  | RST NAME   |  | FIRST NAME   |  |  |
| PHONE FAX  | PHONE  | FA   | x  | PHONE  | FAN.   |  |
| 55-105-1234 55J-55-9   | 321  |  |  | FIIONE   | FAX  |  |
| C-HPILL  | E-MAIL   | _  |  | E-MAIL   |  |  |
| INSTITUTION / DEPARTMENT INSTITUTION   |  | TTUTION / DEPARTMENT   |  |  |  |  |
| 17-11-11   | morrow De Anti-  | PEPARTMENT   |  | INSTITUTION / DEPARTM  | STITUTION / DEPARTMENT   |  |
| ABC Hospital   | 1  | 200  |  |  |  |  |
| STREET ADDRESS   | STREET AD RES  |  |  | STREET ADDRESS   |  |  |
| 123 Hospital Dr.   |  |  |  |  |  |  |
| And the second   | CITY   | PRIVINCE CI  |  | CITY   | PROVINCE   |  |
| POST CODE COUNTRY  | POST CODE  |  |  |  | 539.5551.55  |  |
|  | POST CODE  | CO   | UNYRY  | POST CODE  | COUNTRY  |  |
| OFFICE CONTACT NAME & E-MAIL   | OFFICE CONTACT NAME  | & E-MAIL   | -  | OFFICE CONTACT MAME  | C SAAN   |  |
|  |  | OFFICE CONTACT NAME & E-MAIL   |  |  |  |  |
|  |  |  |  |  |  |  |
| SECTION IV. PATIENT  | SECTION V  | . BILLING-   | Please select ONE hilling or payment   | ontion and complete the  | info N. C  |  |
| SECTION IV. PATIENT  LAST NAME FIRST NAME  | SECTION V  |  | Please select ONE billing or payment   |  | information. (See reverse for details.)  |  |
| LAST NAME FIRST NAME Tane  | SECTION V  |  | Please select ONE billing or payment   |  |  |  |
| LAST NAME FIRST NAME  DOC DATE OF BIRTH (Day / Month / Year)   | SUBMITTING DIAG  | NOSIS_B/   | east (an   | cer  | ICD-10 CODE  |  |
| LAST NAME FIRST NAME Tane  | SUBMITTING DIAG  | NOSIS_B/   | east (an   | cer  | ICD-10 CODE  |  |
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| LAST NAME FIRST NAME  DOC DATE OF BIRTH (Day / Month / Year)   | SUBMITTING DIAG  | tion: 1) INSU  | PRANCE 2) TINSTITUTION / H   | OSPITAL (Restricted to   | contracts on file with GHL) 3) PATIENT   |  |
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| AST NAME  FIRST NAME  Jack  Date of Birth (Day / Month / Year)  SI / OI / 1965  Female  Male  MEDICAL NOMBER  STREET ADDRESS  CITY  PROVINCE  POST CODE  COUNTRY  PHONE  E-MAIL  SECTION VI.  SPECIMEN RETRIEVAL  LOCATION OF SPECIMEN  PHONE  FAX  STATEST ADDRESS  Ordering Physician to request specimen.  SECTION VII.  PHYSICIAN SIGNATURE (Required)  X  AND  DATE (DI   | SUBMITTING DIAG  Select one billing op  INSURANCE OF INSTITUT  PATIENT INSURANCE NU  STREET ADDRESS  COUNTRY  SPECIMEN  1-7679 | NOSIS BI  Please of the state o | PRANCE 2) INSTITUTION / H complete below for bill insurance or institution / H comple | OSPITAL (Restricted to ditution option & attach of the control of  | ICD-10 CODE  contracts on file with GHL) 3) PATIENT  ropy of Insurance card.  ON NUMBER  POST CODE  Ing? YES NO  DATE OF SURGERY (Day/Month/Year)  29/07/20/5  |  |
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| AST NAME  FIRST NAME  JOC  DATE OF BIRTH (Day / Month / Year)  SI / OI / 1965  Female  Male  MEDICAL NOMBER  STREET ADDRESS  CITY  PROVINCE  POST CODE  COUNTRY  PHONE  E-MAIL  SECTION VI.  SPECIMEN RETRIEVAL  Genomic Health to request specimen on my behalf.  LOCATION OF SPECIMEN  PHONE  Ordering Physician to request specimen.  SECTION VII.  PHYSICIAN SIGNATURE (Required)  X  NAME  NAME  DATE (D. X)  DATE (D. X)  NAME   | SUBMITTING DIAG  Select one billing op  INSURANCE OF INSTITUT  PATIENT INSURANCE NU  STREET ADDRESS  COUNTRY  SPECIMEN  1-7679 | NOSIS BI  Please of the state o | PRANCE 2) INSTITUTION / H  Omplete below for bill insurance or inst  Can cer A  TION (REQUIRED)  RIES Is more than one primary tumor Specimens will be processed as  NUMBER cimen is typically required  2122-A  SPECIMEN STATUS  firms that you have read and accept at either 1) the patient meets the crite a, that you have selected the exception ou should your patient not meet these outshould your patient not meet these outshould your patient not meet these counts are the crite as the c | OSPITAL (Restricted to ditution option & attach of the control of  | ICD-10 CODE  contracts on file with GHL) 3) PATIENT  ropy of Insurance card.  ON NUMBER  POST CODE  Ing? YES NO  DATE OF SURGERY (Day/Month/Year)  29/07/20/5  |  |
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