CodeX 科德施 GENETICS

TEST REQUEST FORM

Laboratory use only- Project Code:

PATIENT INFORMATION	SAMPLE INFORMATION
Name:	Date of Collection: *(DD/MM/YYYY)* Time: *(HH/MM)*
Last name First name	
HKID/ Passport no:	Sample Type (Please select one):
Date of Birth: *(DD/MM/YYYY)*	☐ Blood (☐ EDTA/☐ Plasma) ☐ Saliva in collection kit
Gender: ☐ Male ☐ Female	☐ Swab (☐Buccal /☐ Nasal) ☐ Urine
Phone number:	☐ Other, please specify:
Clinical Diagnosis:	

REPORTING INFORMATION	
Ordering Physician:	Email:
Institution:	Phone:
Route of report delivery: ☐ Email / ☐ Mail / ☐ Fax	Fax:

Please put a "✓" in the box(es) to indicate the test(s) to be performed.

Neurology

Alzheimer's Disease
- ☐ CoGenesis® AD
- ☐ APOE Test
- ☐ p-Tau 217 Test
- ☐ Amyloid- Beta 42/40 Ratio
- ☐ NfL Test
- ☐ α-Synuclein Test
- ☐ GFAP Test
- ☐ Precivity AD2™

Neurofibromatosis
- ☐ Neurofibromatosis type 1 & 2 (NF1 & NF2) panel

Movement & Neurodegenerative Disorders
- ☐ Amyotrophic Lateral Sclerosis (ALS) & Frontotemporal Dementia (FTLD) Panel
- ☐ CoGenesis® Neuro
- ☐ CoGenesis® Myopathy
- ☐ Spinocerebellar ataxia (SCA) Panel
- ☐ Retinitis Pigmentosa Panel

WES/WGS
- ☐ Whole Exome Sequencing (WES)
- ☐ Whole Genome Sequencing (WGS)

Paediatrics

Neurodevelopmental disorders
- ☐ CoGenesis® ASD

Recessive Diseases Carrier Test
- ☐ CoGenesis® Family (Partner's HKID no._____)

Cardiovascular Disease
- ☐ CoGenesis® CVD

Pharmacogenomics
- ☐ CoGenesis® Drug Response

Cancer

Hereditary Cancer Screening

Specify TAT: ☐ Standard (4 weeks) ☐ Paid- Accelerated (14 working days)
- ☐ CoGenesis® Pan-Cancer (Please also fill in the *Health Information Questionnaire*)
- ☐ CoGenesis® BRCA-Pro (Please also fill in the *Health Information Questionnaire*)
- ☐ CoGenesis® Colo
- ☐ CoGenesis® Gastric
- ☐ CoGenesis® Pancreas
- ☐ CoGenesis® Prostate

Somatic Cancer Diagnosis
- ☐ CONCISE ColoScan (Please also fill in the *Tissue Handling Authorization Letter*)
- ☐ CONCISE LungScan (Please also fill in the *Tissue Handling Authorization Letter*)
- ☐ CONCISE EGFR

Infectious Diseases
- ☐ EBV Real-time PCR (☐ Qualitative ☐Quantitative)
- ☐ HBV Real-time PCR
- ☐ HPV Real-time PCR
- ☐ STD Combo (☐ for 3 ☐ for 9 ☐ for 13)

Designed Panel/Other, Please Specify:

Please call **3008 2560** or fax this form to **2381 8688** to arrange for sample collection.

Requesting Physician:

Print Name: Signature: Date (DD/MM/YYYY):

免責聲明及同意書

本免責聲明及同意書由科德施基因有限公司（Codex Genetics Limited，以下簡稱「本公司」）發出。

請仔細通讀此同意書。如果您還有其他疑問，請向本公司查詢。 您有權在任何時候改變主意，包括在簽署本同意書後。您亦有權隨時向科德施基因查閱或更改您在科德施基因登記的個人資料。本人確認本表格所提供的資料準確無誤。

本人同意本同意書所述的測試將由本公司進行。

- 本人已明白我所進行的測試的目的、範圍及限制。
- 本人的測試結果將發送至本人的醫生，本人將在結果準備就緒時從醫生處獲取相關資訊。
- 您的個人資料受《個人資料(私隱)條例》(PDPO) 及 ISO27001 國際標準保障，將僅用於診斷用途；您可選擇**授權 / 不授權***我們使用經去識別化/匿名化處理的數據進行研究以優化服務，我們會實施嚴格安保措施防止未經授權的存取、使用或披露。您的個人資料將被保存至少四年，或按法律及認證標準（包括《個人資料（私隱）條例》及 ISO 15189）之要求保留。您可聯絡我們查閱或要求刪除您的個人資料，惟須符合相關法律規定。
- 本人已閱讀並理解本表格中上述信息，特此同意本公司對上述樣品進行相關化驗項目，並代表本人取回上述樣本和病理報告，也了解樣本可能會在測試過程中消耗。
- 若進行測試人士未滿 18 歲，本人作為其法定監護人，代表測試人士同意其接受該基因檢測，並同意按照上述規定處理測試人士的個人資料。

***請刪去不適用選項**

Disclaimer and consent form

This Disclaimer and Consent Form is issued by Codex Genetics Limited (hereinafter referred to as "the Company").

Please read this consent form carefully. If you have any questions, please contact the Company. You have the right to change your mind at any time, including after signing this form. You may also access or amend your personal information registered with the Company at any time. I confirm that the information provided in this form is accurate.

I agree that the test described in this consent form will be conducted by the Company.

- I understand the purpose, scope, and limitations of this test.
- My test results will be sent to my doctor, and I will obtain the relevant information from my doctor when the results are ready.
- Your information is protected under the Personal Data (Privacy) Ordinance (PDPO) and ISO27001 standards; it will be used for diagnostic purposes, and you may **authorize/ not authorize*** the use of deidentified/anonymized data for research to improve our services, with strict security measures in place to prevent unauthorized access. Your personal data will be kept for at least four years, or as required by law and accreditation standards (including the Personal Data (Privacy) Ordinance and ISO 15189). You may contact us to request access to or deletion of your data, subject to legal requirements.
- I consent to Codex Genetics Limited conducting the tests indicated above and retrieving the sample and pathology report on my behalf, understanding that the sample may be consumed during testing.
- If the individual is under 18 years of age, I, as the legal guardian, consent on behalf of the individual to undergo this test and agree to the handling of their personal data as outlined above.

*Please delete the option that does not apply.

Patient:

Print Name: _____ Signature: _____ Date (DD/MM/YYYY): _____

Codex Genetics Laboratory use only

Receipt date & time:

Received by:

Data Privacy and Patient Authorization

By submitting this test request and corresponding patient samples, the referring physician confirms that the patient's consent or authorization has been duly obtained for the collection, use, and disclosure of their personal data — including name, date of birth, gender, biological samples, and test results — for the purpose of performing and reporting the requested medical tests. The referring physician further acknowledges that such data will be handled in accordance with applicable data protection and privacy laws and the laboratory's confidentiality and information security policies.

FILL IN WHEN NECESSARY

[Fill this form ONLY when tissue specimen retrieval from third-party laboratory is needed]

Date: _____

To: Histopathology Laboratory, _____*(Hospital Name)*

RE: Sample Retrieval and Preparation for Cancer Tissue Testing for Patient _____*(Name)*, HKID:_____

To Whom It May Concern,

Please accept this letter as formal authorization to your laboratory to:

1. **Retrieve** archived tissue specimen(s) of the indicated patient,
2. **Prepare** the specimen(s) based on the specimen requirements of the selected test request, and
3. **Release** the prepared specimen(s) to the **Codex Genetics** in handling all test requisition documents to the third-party service provider and local logistics for sample pick-up and transportation.

☐ **For Guardant360 TissueNext + PDL1 Dako22C3:**

8 FFPE unstained coated slides

(***NOTE***: Tissue biopsy with tumor content of 5-10%, additional slides up to **10-12 slides** is preferred)

☐ **Additional Guardant IHC Testing:**

*(*Please check the box for each additional test request)*

Additional Biomarker(s)	No. of additional FFPE slides required
☐ **c-MET**	+1
☐ **HER2**	+1
☐ **Ki-67**	+1
☐ **ER/PR**	+2
☐ **FOLR1**	+2
☐ **CLDN18**	+3

Total No. of Slides Submitted: _____

Guardant IHC FFPE Slide Requirement:

- 5μm thick each
- Surface Area
  - Minimum: ≥ 2 mm^2
  - Optimum: 25mm^2
- Tumor Content
  - Minimum: ≥ 5%
  - Optimum: ≥ 20%

Pathology report is required.

☐ **For CONCISE LungScan / ColoScan**

10 FFPE unstained coated slides

CONCISE IHC FFPE Slide Requirement:

- 5μm thick each
- Surface Area **≥ 20 mm^2**
- Tumor Content : ≥ 5%

Pathology report is required.

Bill to: Codex Genetics Limited, Unit 220, 2/F, Hong Kong Science Park 16W, Shatin, N.T.

For any enquiries, please contact Ms. Sherie Lee (Codex Genetics) at 3008 2560 for specimen collection and logistics.

I, **Dr.** _____*(Dr. Name)*, hereby to confirm that the indicated patient has understood and accepted the recommendation for the genetic testing service, that this specimen retrieval and preparation is medically indicated. I authorize both your laboratory and Codex Genetics to proceed as outlined.

Yours Sincerely,

Clinician Name: **Patient Name:**

Clinician Signature: **Patient Signature:**