

*Please select your finance billing type:

<input type="checkbox"/> New Guardant Patient	For Existing Guardant Patient, please check:	<input type="checkbox"/> Re-Test due to previous No Mutation Detected (NMD) Reporting (either Liquid/Tissue) (*Only eligible within 8 weeks after the NMD reporting)	<input type="checkbox"/> Bundle Test (Liquid + Tissue)
		<input type="checkbox"/> Previous user of Tissue / Liquid	



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CLIA # 05D2070300 | CAP Accredited # 8765297 | LBL-000317 R2




Place
Barcode
Here

Guardant360® and Guardant360 Response™ Test Requisition

All shaded boxes are REQUIRED to be completed

<h3>1. PATIENT INFORMATION</h3> <table border="1"> <tr> <td colspan="2">Last Name</td> <td colspan="2">First Name</td> </tr> <tr> <td colspan="2">DOB (dd/mmm/yyyy)</td> <td>Sex</td> <td>Medical Record Number / Patient ID</td> </tr> <tr> <td colspan="2">Street Address</td> <td><input type="checkbox"/> F</td> <td><input type="checkbox"/> M</td> </tr> <tr> <td>City</td> <td>State</td> <td>Country</td> <td>Postal Code</td> </tr> <tr> <td colspan="4">Preferred Contact Phone Number</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> New Guardant360 Patient</td> <td colspan="2"><input type="checkbox"/> Existing Guardant360 Patient</td> </tr> </table>	Last Name		First Name		DOB (dd/mmm/yyyy)		Sex	Medical Record Number / Patient ID	Street Address		<input type="checkbox"/> F	<input type="checkbox"/> M	City	State	Country	Postal Code	Preferred Contact Phone Number				<input type="checkbox"/> New Guardant360 Patient		<input type="checkbox"/> Existing Guardant360 Patient		<h3>4. ORDERING PHYSICIAN (or other Licensed Medical Professional)</h3> <table border="1"> <tr> <td colspan="2">Last Name</td> <td colspan="2">First Name</td> </tr> <tr> <td colspan="4">Hospital / Institution</td> </tr> <tr> <td colspan="4">Email</td> </tr> <tr> <td>Account Name</td> <td>Codex Genetics Limited</td> <td>Account Number</td> <td>GHI-029316</td> </tr> <tr> <td>Account Address</td> <td colspan="3">#220 2/F Bldg 16W No.16 Science Park W Ave</td> </tr> <tr> <td>City</td> <td>Shatin</td> <td>State / Province</td> <td></td> </tr> <tr> <td>Postal Code</td> <td></td> <td>Country</td> <td>HK</td> </tr> <tr> <td>Phone Number</td> <td></td> <td>Fax</td> <td></td> </tr> </table> <p>Medical Professional Consent</p> <p>My signature constitutes a Certification of Medical Necessity, and I hereby authorize and order Guardant Health, Inc. (GH) to perform Guardant360 testing and curation for this patient as indicated on this requisition. I have reviewed the medical consent on the back of this form and will provide test interpretation to the patient as appropriate. (continued on back)</p> <p>Medical Professional Signature _____ Date _____</p> <p>X</p>	Last Name		First Name		Hospital / Institution				Email				Account Name	Codex Genetics Limited	Account Number	GHI-029316	Account Address	#220 2/F Bldg 16W No.16 Science Park W Ave			City	Shatin	State / Province		Postal Code		Country	HK	Phone Number		Fax	
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<h3>2. BLOOD SPECIMEN INFORMATION</h3> <table border="1"> <tr> <td>Collection Date (dd/mmm/yyyy)</td> <td>Name of Person Collecting Specimen</td> </tr> </table>	Collection Date (dd/mmm/yyyy)	Name of Person Collecting Specimen	<h3>3. ADVANCED CANCER STAGE (REQUIRED)</h3> <p>Stage I/II not currently accepted</p> <p><input type="checkbox"/> Advanced Cancer (Stage III/IV)</p> <p>Currently on Therapy? If yes, please list below (REQUIRED for Guardant360 Response test)</p> <p><input type="checkbox"/> Targeted Therapy <input type="checkbox"/> Immunotherapy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Combination Therapy</p> <p>Specific therapy ▶ _____</p>																																																						
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5. TEST SELECTION (REQUIRED; SELECT ONE)

<input type="checkbox"/> 74-Gene Panel Guardant360 74-gene panel including: <ul style="list-style-type: none"> Microsatellite instability (MSI) status  <p>Barcode is for Internal Use Only</p>	OR <input type="checkbox"/> 700+ Gene Panel Guardant360 Expanded-gene panel including: <ul style="list-style-type: none"> Microsatellite instability (MSI) status Blood tumor mutational burden (bTMB) Expanded coverage of homologous recombination repair (HRR) genes  <p>Barcode is for Internal Use Only</p>	OR <input type="checkbox"/> Response Guardant360 Response Assesses treatment response: Utilizes ctDNA to evaluate response to therapy 4-10 weeks after treatment initiation. Requires previous testing with Guardant360.  <p>Barcode is for Internal Use Only</p> <p>Date of Therapy Initiation (dd/mmm/yyyy) ▶ _____</p>
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6. DIAGNOSIS (REQUIRED to select one)

Date of original diagnosis (dd/mmm/yyyy) _____

BRAIN <input type="checkbox"/> Glioblastoma <input type="checkbox"/> Other Primary CNS Tumor ▶ _____	GENITOURINARY <input type="checkbox"/> Bladder Carcinoma <input type="checkbox"/> Prostate Adenocarcinoma <input type="checkbox"/> Renal Cell Carcinoma <input type="checkbox"/> Urothelial Carcinoma <input type="checkbox"/> Other Genitourinary Tumor ▶ _____	GYNECOLOGIC <input type="checkbox"/> Endometrial Carcinoma <input type="checkbox"/> Ovarian Carcinoma <input type="checkbox"/> Other Gynecologic Tumor ▶ _____	SARCOMA <input type="checkbox"/> Sarcoma <input type="checkbox"/> Other Sarcoma ▶ _____
BREAST <input type="checkbox"/> Breast Carcinoma <input type="checkbox"/> Other Breast Tumor ▶ _____	GI <input type="checkbox"/> Cholangiocarcinoma <input type="checkbox"/> Colorectal Adenocarcinoma <input type="checkbox"/> Esophageal/Gastroesophageal Junction Adenocarcinoma <input type="checkbox"/> Gastric Adenocarcinoma <input type="checkbox"/> Hepatocellular Carcinoma <input type="checkbox"/> Pancreatic Ductal Adenocarcinoma <input type="checkbox"/> Other Gastrointestinal Tumor ▶ _____	HEAD & NECK <input type="checkbox"/> Head and Neck Carcinoma ▶ _____	SKIN <input type="checkbox"/> Melanoma <input type="checkbox"/> Other Skin Tumor ▶ _____
	LUNG <input type="checkbox"/> Adenocarcinoma (NSCLC) <input type="checkbox"/> Large Cell Carcinoma (NSCLC) <input type="checkbox"/> Squamous Cell Carcinoma (NSCLC) <input type="checkbox"/> Small Cell Lung Carcinoma <input type="checkbox"/> Other Lung Tumor ▶ _____	THYROID <input type="checkbox"/> Thyroid Carcinoma ▶ _____	OTHER <input type="checkbox"/> Carcinoma of Unknown Primary (CUP) <input type="checkbox"/> Other ▶ _____

7. RELEVANT CLINICAL HISTORY

1. The patient is seeking treatment and: is newly diagnosed (Stage III/IV). has tumor that is not responding to therapy. If positive, list mutation: _____

2. Has tissue- or liquid-based CGP from a recent biopsy already returned an actionable result? No Yes _____

8. BILLING INFORMATION

Hospital/Institution Distributor Project Code ▶ _____



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Test Requisition & Statement of Medical Necessity *continued*

4. Medical Professional Consent *(continued from front)*

I have informed the patient regarding somatic genomic testing, and the patient has consented for the tests ordered. The patient understands that his/her anonymized results may be used by GH for the purpose of laboratory test improvement and publication of aggregated data. I understand that GH is relying on the diagnosis I have provided on the test requisition form in providing information about potential therapeutic options and clinical trials associated with the reported testing results, and that an incorrect diagnosis would adversely affect the relevance of the information provided by GH. I understand that I remain free in my medical decisions on how to use the results of any Guardant Health product(s) in my management of this patient. I have obtained the patient's written consent to transmit the health data on this requisition form for the purpose of processing this order and performing all ordered Guardant Health tests.

Patient Consent

1. I have been informed by my physician about the purpose, scope, and limitations of the test ordered.
2. I understand that my blood sample will be collected and transported by third party logistics carriers to Guardant Health, Inc. in the US for analysis and interpretation and there may be delays in the transport of the blood sample. I will not hold Guardant Health, Inc. responsible for such delays, if any.
3. I am aware that my personal data and health information will be subject to the privacy and data protection rules of Guardant Health, Inc. and the US data privacy laws, which may be different from those in my country. In accordance with applicable law, Guardant Health may aggregate or deidentify personal data for its scientific research purposes related to cancer diagnostic product improvement and development. In such case, my identity is not known during such research activities.
4. I have been informed of who may have access to my sample and test results which form part of my confidential medical records. I also understand that personal information relating to me, including my name, date of birth, contact details, sample details, and test results will be processed and stored by third parties appointed by Guardant Health Inc. and or its Affiliates, necessarily involved in the process of ordering, taking, collecting, delivering, testing my sample and reporting. I hereby give my consent to such processing and storage of my personal information.
5. I understand that the results of the test will be sent or made available to my physician and when the results are ready, I will collect the information from my physician.
6. I have read and understand the information set out above in this form and I had the opportunity to ask any questions that I might have regarding the test and the process related to the test and received satisfactory answers from my physician. I hereby agree to undergo the test.
7. For patient under 18 years of age, I am the guardian and on behalf of the patient, I hereby agree for the patient to undergo the test and for the patient's personal information to be processed as set out above."

✕

SIGNATURE OF PATIENT

PRINT NAME OF PATIENT

DATE