CLINICAL GENOMICS – ONCOLOGY

All Fields Required

The Jackson Laboratory
Leading the search for tomorrow's cures

PATIENT INFORMATION

Name (First, MI, Last)		Date of Birth	Sex ☐Male ☐Female
Address			
City	State	Zip Code	Country
Primary Phone #		Medical Record #	

ORDERING PHYSICIAN INFORMATION

Treating Physician Name		NPI #	
Practice/Institution			
Facility Address			
City	State	Zip Code	Country
Primary Phone #	Fax # or Email		

TEST MENU *Please choose the appropriate test to be executed on the submitted specimen*

☐ **JAX SOMASEQ™** ☐ **JAX SOMASEQ™ Complete** – *Includes PD-L1 IHC* ☐ **JAX OncoMethyl™ Array**

SPECIMEN INFORMATION *Please see specimen requirements for test specific acceptance criteria*

Specimen ID	Specimen Site
Date & Time Collected	Primary Specimen Site
Date Removed From Storage	Diagnosis

BILLING INFORMATION *Please check one*

☐ ***Insurance*** *(attach copies of front and back of card) or* ☐ ***Medicare – Part B***

Company Name		
Member ID	Group	
Insured Name	Relationship to Patient	☐ Self ☐Spouse ☐Child ☐Other
City	State	Zip Code
Date of Birth	Phone	

Patient Status (check one) ☐ Inpatient – Date of Discharge: _____ ☐ Outpatient ☐ Non-Hospital Patient

Note: A complete Advance Benefit Notice (ABN) of coverage is required for all Medicare patients (see www.jax.org/clinical-genomics or contact JAX for form)

☐ ***Institution or Study***

Institution/Study Name	Account/Study #

☐ ***Self-pay***

Contact Name	Email	Phone #

AUTHORIZATION

I certify (a) that the laboratory test requested is medically necessary and will assist me in treating my patient, (b) that I have informed the patient and/or their legal representative of the benefits, risks, and limitations of the test, (c) and that I have obtained the patient's informed consent, to the extent legally required, to permit The Jackson Laboratory to (i) perform the testing specified herein, (ii) retain the test results for an indefinite period for internal quality assurance/operations purposes, (iii) de-identify the test results and use or disclose for future unspecified research or other purposes, and (iv) release the test results to the patient's third party payor as needed for reimbursement purposes.

Ordering Physician Signature **Date**

Laboratory Use Only

Date and Time of Specimen Receipt	Accessioning Tech Initials	Specimen ID #
Notes/Event #		Patient ID #

SPECIMEN REQUIREMENTS

Specimen Type	Available Tests	Shipping Temperature	Sample Storage for Transport	Amount & Quality Requirements
FFPE Slides	JAX SOMASEQ™ JAX SOMASEQ™ Complete	Ambient	Uncoated, unbaked slides placed in plastic slide containers	1 H&E slide and 10 adjacent unstained 5um sections. (3 additional unstained slides needed if SomaSeq Complete is ordered). Area of tumor cell content should be a minimum of 3x3mm or 5,000 cells and be comprised of at least 30% cancer cells.
	JAX OncoMethyl™ Array			1 H&E slide and 10 adjacent unstained 5um sections. Area of tumor cell content should be a minimum of 3x3mm or 5,000 cells and be comprised of at least 70% cancer cells. Necrosis and inflammation in the area of highest neoplastic content should be deemed "Mild" or less.
FFPE Blocks	JAX SOMASEQ™ JAX SOMASEQ™ Complete	Ambient	Sealed biohazard bag	Area of tumor cell content should be a minimum of 3x3mm or 5,000 cells and be comprised of at least 30% cancer cells.
	JAX OncoMethyl™ Array			Area of tumor cell content should be a minimum of 3x3mm or 5,000 cells and be comprised of at least 70% cancer cells. Necrosis and inflammation in the area of highest neoplastic content should be deemed "Mild" or less.

All specimens must be accompanied by a pathology report.

Unacceptable FFPE specimens include specimens fixed/processed in alternative fixatives (e.g., alcohol or heavy metal fixatives), decalcified specimens, and frozen specimens.

During warm summer months, please ship FFPE slides and blocks in a cooled shipping container to prevent melting during transit.

All specimens should be shipped priority overnight in appropriate packaging container per relevant shipping conditions (see table above) and comply with relevant shipping criteria (e.g., DOT and/or IATA). Shipments should be planned to arrive to JAX Monday-Friday only.

Please label all specimens with at least two identifiers corresponding to the patient or specimen information provided on this form and ensure that this completed form is included in the shipment.

Any specimens not meeting the above criteria will be processed at the discretion of the Clinical Laboratory Director. All samples are subject to additional downstream QC requirements. Please contact the laboratory for questions regarding acceptable specimens.

OTHER INDIVIDUALS TO BE COPIED ON REPORT

Name	Name
Email or Fax #	Email or Fax #

SHIPPING ADDRESS

Clinical Genomics Laboratory
The Jackson Laboratory for Genomic Medicine
10 Discovery Drive
Farmington, CT 06032

CONTACT JAX

Phone # 860-837-2320
Fax # 860-837-2380
Email CGL_CS@jax.org
Please use this email for service-related questions only. Due to the sensitive nature of PHI, do not submit this requisition via unencrypted email.