



A Ordering Physician Information (Required)*

Ordering Physician (Full Name)			NPI
Office / Practice / Institution Name / Clinic		CCDx Account Number	
Street, Address, Unit			
State	Postal Code	Country	Email Address (Required for Report Delivery)

B Patient Information (Required)*

Last Name		First Name		Middle Initial	Medical Record #		
Race (Select all that apply): ☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Pacific Islander ☐ White		☐ Other (specify): _____ ☐ Unknown / Not Reported Ethnicity (Select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown / Not Reported		DOB	Biological Sex	Phone	Schedule Mobile Phlebotomy ☐ Yes ☐ No
Street, Address, Unit							
City		State		Postal Code			

C Testing Options

Individual Testing Options

Select below:

☐ CellSight™ DNA

D Specimen Information (Required)*

Patient status at the time of specimen collection

(Required — select one):

☐ Office/Non-Hospital

☐ Hospital Outpatient

☐ Hospital Inpatient

☐ Not yet discharged

OR Discharge date:

Specimen Type

☐ Blood

Date of Collection:

Specimen Collection & Shipping Instructions

- 1 Prepare & Label:** Confirm kit contents; label both CellSave tubes with patient info and TRF number.
- 2 Collect Sample:** Draw two 10 mL tubes, fill to line, gently invert 8–10× to mix; do not shake.
- 3 Complete TRF:** Fill out all fields, provider info, and test requests; place in outer sleeve.
- 4 Package & Chill:** Place tubes in biohazard bag with liner, add frozen ice pack below, seal at 2–8 °C.
- 5 Ship & Confirm:** Call courier or FedEx for same-day pickup, seal box, track shipment, confirm lab receipt.

E Clinical Information (Required)*

Current Cancer Diagnosis ☐ Bladder ☐ NSCLC ☐ Breast ☐ Ovarian ☐ Colorectal ☐ Prostate ☐ Melanoma ☐ Other: _____		Disease Status ☐ Metastatic, refractory, relapsed or recurrent ☐ No Evidence of Disease ☐ Other: _____	Date of Original Diagnosis	Primary ICD-10 (Required):
			Clinical Stage	☐ Pathology Report Attached
			Reason for Testing	Has Patient had any type of transplant? ☐ Yes ☐ No Type: _____

F Billing Information (Required)*

Bill Type: ☐ Insurance ☐ Hospitals/Institution ☐ Self pay ☐ Medicare ☐ Medicaide			
Primary Insurance		Policy #	Group #
Patient relationship to policy holder ☐ Self ☐ Spouse ☐ Child ☐ Other: _____		Policy Holder Name (Not applicable if self)	Policy Holder DOB (Not applicable if self)

G Physician Signature and Patient Consent (Required)*

PHYSICIAN SIGNATURE I certify that I have explained to the patient the purpose, risks and benefits of the test being ordered. My signature below is my certification of medical necessity for the test and further certifies that I have obtained from the patient informed consent that meets the requirements of applicable law for Cancer Cell Diagnostics to: (a) perform the test described in this form; (b) obtain, receive, and release, test results and any corresponding medical information as necessary for reimbursement or the processing of insurance claims; (c) retain samples and information obtained from the patient, including the test results, for an indefinite period of time; (d) use information obtained from the patient and the test results in accordance with applicable law, including de-identifying such information and disclosing the de-identified information for other purposes.

Ordering Physician Signature

Date(MM/DD/YY)

Printed Name