

MOLECULAR ONCOLOGY TEST REQUISITION FORM

Please write legibly. All fields need to be completed in English.

Any missing information may cause a delay in the turnaround time of the test.

Patient Information

Given Name	Last/Family Name
Sex at Birth	Date of Birth (DD/MM/YYYY)
☐ Male ☐ Female	
Address	
Postal Code	Country
Patient ID (NRIC/Passport No.)	Nationality
Diagnosis <i>(please indicate specifically)</i>	Stage/Primary Site
Treatment History <i>(schedule, cycle and effect)</i>	Operation History

Treating Physician Information

Given Name	Last/Family Name
Hospital/Clinic	
Address	
Postal Code	Country
Telephone	Practicing Licence No.
Metastasis? Yes	☐ Lymphatic metastasis? ☐ Yes
Prefer e-Report? ☐ Yes	Email Required:

Clinical Summary *(attached notes separately if needed)*

Test Panel Selection* (tick where appropriate)

Tissue Biopsy

- ☐ **HapOnco® WESPlus** (CA0001)
- ☐ **HapOnco® StarPanel** (CA0002)
1326 genes
- ☐ **HapOnco® CorePanel** 136 genes incl. 12 fusion genes, MSI
☐ (CA0004) Without germline control ☐ (CA0005) With germline control
- ☐ **HapOnco® IO Safety** (CA0009)

Please add IHC PD-L1 testing

Liquid Biopsy

- ☐ **HapOnco® StarPanel** (CA0003)
1326 genes
- ☐ **HapOnco® CorePanel** (CA0006)
136 genes incl. 12 fusion genes, MSI
- ☐ **HapOnco® IO Safety** (CA0010)

- ☐ **HapOnco® Lung Cancer BasicPanel™** (CA0033)
11 genes incl. 4 fusion genes

- ☐ **HapOnco® Colorectal Cancer BasicPanel™** (CA0034)
23 genes incl. 7 fusion genes

- ☐ **HapOnco® Glioma BasicPanel™** (CA0035)
18 genes incl. MGMT promoter methylation

MRD

- ☐ **HapOnco® mClear MRD**
☐ (CA0011) WESPlus + Personalized MRD*5
☐ (CA0012) 1 follow-up test
☐ (CA0013) 5 follow-up tests

- ☐ **HapOnco® Lung Cancer MRD** 170 Genes
☐ (CA0014) Post-surgery 1st test ☐ (CA0015) 1 follow-up test ☐ (CA0016) 5 follow-up tests

- ☐ **HapOnco® Digestive Tract Cancer MRD** 190 Genes
☐ (CA0017) Post-surgery 1st test ☐ (CA0018) 1 follow-up test ☐ (CA0019) 5 follow-up tests

- ☐ **HapOnco® Hepatobiliary & Pancreatic Cancer MRD** 796 Genes
☐ (CA0020) Post-surgery 1st test ☐ (CA0021) 1 follow-up test ☐ (CA0022) 5 follow-up tests

Others

- ☐ **HapOnco® PARPrion** (CA0008)
HRD, SNV/Indel of 35 HRR genes (including BRCA1/2)
- ☐ **HapOnco® Breast21** (CA0042)
21 genes, recurrence risk

- ☐ **HapOnco® BRCA1/2** (CA0028)
Germline

- ☐ **HapOnco® Hereditary Cancer Comprehensive** (CA0023)
89 Genes

- ☐ **HapOnco® Hereditary Breast Cancer & Gynecological Cancer** (CA0024)
30 Genes

- ☐ **HapOnco® Hereditary Colorectal Cancer** (CA0025)
26 Genes

*Refer to reverse for tissue specimen guidelines & requirements. Full list of genes available upon request.

Treating Physician's Declaration & Confirmation of Informed Consent for Genetic Testing

I declare that the information provided is accurate and true to the best of my knowledge at the time of submission. My signature attests that I am a licensed medical professional and the patient's treating physician authorised to order genetic testing. I attest that the testing is medically necessary and that the test results may impact the medical management of the patient. I have also explained the purpose and limitations of the test(s) to be performed and have obtained the patient/parent/legal guardian's informed consent, to the extent required by applicable law, to allow LifeStrands Genomics (LSG) or any laboratory with which LSG has contracted to perform the test(s) specified herein, including the use & storage of samples for diagnosis, future monitoring, internal quality assurance/operations, and future unspecified research or other purposes.

Signature	Full Name	Date (DD/MM/YYYY)
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Patient's Declaration & Confirmation of Informed Consent for Genetic Testing

This form must be fully completed and signed by you, your legal guardian, or a legally authorized representative. Please read it carefully and discuss it with your ordering physician, healthcare provider, or the individual obtaining consent before signing.

Purpose

HapOnco® genetic testing is designed to look for cancer-related genomic alterations (mutations or variants) or/and other supplementary biomarkers. This information can assist your physician in determining the most appropriate treatment options, including targeted therapies or suitable clinical trials. The test offers several options with different gene selections to meet various needs. Please consult your physician to choose the best option for you.

Procedure

The sample(s) of your tumor (either tissue and/or blood) will be sent to a HaploX laboratory, where DNA will be isolated, sequenced, and analyzed for cancer-related genomic alterations or/and other supplementary biomarkers. HaploX will then provide a detailed report to your healthcare provider, who will evaluate your cancer's specific genetic profile along with other relevant information (e.g., your medical history and results of other tests) to develop the best treatment plan.

Limitations and potential risks

1. HapOnco® only collects the information necessary for testing, and HaploX is committed to protecting the confidentiality of personal data and test results. Personal information is disclosed only to sample reception personnel and related technicians, while test reports are provided exclusively to the patient and/or their attending physician. HaploX ensures the security of all personal data.
2. Despite the use of rigorous testing procedures, limitations in current medical technology, along with individual differences and sample variability, may still result in false positives or false negatives. Additionally, the absence of detected mutations in specified genes does not entirely rule out the presence of mutations that may be below the detection threshold.
3. This test (except for HapOnco® WESPlus) focuses on detecting mutations in specific tumor-related genes and does not analyze all genes in tumor cells. Given the current progress in anticancer drug development, not all types of cancer have effective treatments, and the test results may not recommend suitable therapies.
4. Sample collection will be performed by medical institutions according to clinical diagnostic standards. Any injuries that occur during sample collection are not covered by this consent document.
5. The report timeline begins once the HaploX laboratory receives the sample. If force majeure or quality control issues prevent testing, the patient must provide a new sample that meets the requirements. The timeline will reset when the new qualified sample is received.
6. If a sample fails quality control, continuing with testing may produce inaccurate or inconclusive results. By choosing to proceed after being informed of these risks, the patient accepts the associated risks of using a substandard sample.
7. The test report should be reviewed and interpreted by qualified medical professionals. HaploX is not liable for any psychological or physical effects resulting from the testing process or learning the test results.
8. This test is intended to assist in clinical diagnosis by providing optional reference information for treatment planning. It does not determine the course of treatment or guarantee outcomes. The attending physician will make the final treatment decisions based on genetic test results and other clinical factors.

Other Important Information

In certain cases, re-sampling may be necessary due to reasons including, but not limited to: damaged sampling tubes, poor sample quality, inaccurate reporting of key medical information, or unforeseen technical issues. If re-sampling is required, no additional charges will apply.

Declaration of Consent

1. I hereby certify that my physician or an employee / representative of the healthcare provider that my physician is practicing at has explained the intended purpose, benefits, and risks of testing as outlined in the consent form.
2. I understand that HaploX Clinical Laboratories is only responsible for the genetic test report. This test is not intended to provide a final diagnosis and should not be relied upon as the sole evidence for a diagnostic conclusion or clinical decision in the event of a positive result.
3. I acknowledge that re-sampling may be required if the initial sample does not meet quality criteria for analysis. No additional charges will be incurred for re-sampling. I consent to have my test results sent to my healthcare provider or to an address they provide. Given the complexity of DNA-based testing and the significance of the results, I understand that my results will be communicated through my healthcare provider, and I should contact them to obtain the results.
4. I understand that the analysis is limited to variations in the genes included in the selected testing option. Due to technical limitations, sample conditions, and individual differences, false positive and false negative results can occur.
5. I acknowledge that my sample or data will be sent to a HaploX-owned and operated laboratory (which may be outside of the country in which my sample or data is obtained) for analysis.
6. I understand that after the report is delivered, any remaining sample (if applicable) will be stored for three years. The quality of the remaining sample may decline over time and cannot be used for validation or re-examination. Sample quality is subject to the quality control results of the formal analysis.
7. I understand that I have the right to request the destruction of any remaining samples (if applicable) and to delete my test data, which I can notify HaploX at any time.

Signature	Full Name	Date (DD/MM/YYYY)
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Pathology & Specimen Information (to be filled by submitting Pathologist reading the case)

Submitting Staff Name	Institution/Hospital Same as above	☐
Address (if different)	Postal Code	Country
Telephone	Email	
Date of Specimen Collection (DD/MM/YYYY)	Specimen site	Specimen ID
Is this a ☐ RELAPSE case? Attach previous report (if any)		Previous specimen ID Ref. (if any): _____