GUARDANTREVEAL™
Residual Disease and Recurrence Monitoring

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CLIA # 05D2070300 | CAP Accredited # 8765297 | FRM-PRT-000077 R3

Place Barcode Here

Guardant Reveal™ Test Requisition & Statement of Medical Necessity

DOES NOT PROVIDE COMPREHENSIVE GENOMIC PROFILING RESULTS

All shaded boxes are REQUIRED to be completed.

1. PATIENT INFORMATION REQUIRED

Last Name / Patient ID | First Name

DOB (dd/mmm/yyyy) | Sex ☐ F ☐ M | Medical Record Number

Street Address

City | State / Province | Postal Code | Country

Preferred Contact Phone Number

☐ New Guardant Health Patient ☐ Existing Guardant Health Patient

2. SPECIMEN INFORMATION REQUIRED

Collection Date (dd/mmm/yyyy) | Name of Person Collecting Specimen

3. STAGE REQUIRED

☐ Stage II ☐ Stage III

4. RELEVANT DATES REQUIRED

Date of Original Diagnosis (dd/mmm/yyyy)

Date of Surgical Resection (dd/mmm/yyyy)

Date of Completion of Adjuvant Chemotherapy (if applicable) (dd/mmm/yyyy)

5. ORDERING PHYSICIAN (or other Licensed Medical Professional) REQUIRED

Last Name | First Name

Hospital / Institution

Email

Account Name: Gene Agnostic Co., Ltd. | Account Number: GHI-035253

Account Address: 300/139 Soi Ladprao 84 (Sung Kom Song-Khao-Tai 1)

Sub-District & District Wang Thong Lang

City: Bangkok | State / Province

Postal Code: 10310 | Country: TH

Phone Number | Fax

Medical Professional Consent

My signature constitutes a Certification of Medical Necessity, and I hereby authorize and order Guardant Health, Inc. (GH) to perform Guardant Health testing for this patient as indicated on this requisition, I have reviewed the medical consent at the bottom of this form and will provide test interpretation to the patient as appropriate. *(continued at bottom)*

Medical Professional Signature | Date

X

6. DIAGNOSIS REQUIRED

COLORECTAL
- ☐ Colon Adenocarcinoma
- ☐ Rectal Adenocarcinoma
- ☐ Other Colorectal

▶ _____

LUNG
- ☐ Adenocarcinoma (NSCLC)
- ☐ Large Cell Carcinoma (NSCLC)
- ☐ Squamous Cell Carcinoma (NSCLC)
- ☐ Other Lung

▶ _____

BREAST
- ☐ Breast Carcinoma (HR+, HER2–)
- ☐ Breast Carcinoma (HR+, HER2+)
- ☐ Breast Carcinoma (HR–, HER2+)
- ☐ Breast Carcinoma (TNBC)
- ☐ Other Breast

▶ _____

7. RELEVANT CLINICAL HISTORY

1. Is the patient currently being treated with radiation or systemic therapy for the diagnosis selected in Section 6? ☐ No ☐ Yes
2. Does the patient currently have clinical, radiographic, or biologic evidence of recurrence or progression? ☐ No ☐ Yes
3. Is the patient currently being tested with another ctDNA MRD surveillance test/program? ☐ No ☐ Yes

8. BILLING INFORMATION REQUIRED

☐ Hospital / Institution ☐ Distributor Project Code ▶ _____

Patient Consent

1. I understand that my blood sample will be collected and transported to Guardant Health, Inc. in the US for analysis and interpretation. I am aware that my personal information will be subject to the privacy and data protection rules of Guardant Health, Inc. and the US, which may be different from those in my country.
2. I have been informed by my physician about the purpose, scope, and limitations of the test ordered.
3. 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.
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 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.
5. I have read this form and I agree to undergo the test. I understand the information set out above and I had the opportunity to ask any questions that I might have had regarding the test and the process related to the test and received satisfactory answers from my physician.

X

SIGNATURE OF PATIENT | PRINT NAME OF PATIENT | DATE

5. Medical Professional Consent *(continued from above)*

As may be required by applicable state laws and regulations, I have supplied information to the patient regarding Guardant Reveal, and the patient has given consent for this testing to be performed by Guardant Health and for the results to be reported back to me in my management of this patient. I have obtained in writing the patient's data privacy consent to transmit the health data on this requisition form for the purpose of processing this order and performing Guardant Reveal. I understand that I remain free in my medical decisions on how to use the results of Guardant Reveal in my management of this patient.

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