

Patient			
Last Name:	First Name:	MI:	
Patient SSN:	Medical Record #:		
Date of Birth:	Gender:		M F
Address 1:			
Address 2:			
City:	State:	Postal Code:	Country:
Primary Phone:		Secondary Phone:	

Ordering Physician:			
Office / Practice / Institution Name:			
Ordering Physician:			
Address 1:			
Address 2:			
City:	State:	Postal Code:	Country:
Phone:		Fax:	

Biopsy Information	
Biopsy Location (Name and State, e.g. Williams Memorial Hospital, MD):	
Biopsy Date:	Biopsy Time:
Physician Performing Procedure:	
Primary Tumor Site:	Specimen Site:
Stage of Disease:	Permission to exhaust tissue sample? Yes No

Physician to be Copied	
Name:	
Hospital / Institution Name:	
Phone:	Fax:

Patient Insurance Information	
Insurance Company:	
Primary Card Holder Name:	
ID Number:	Insurance Company Phone:

Perthera provides consulting services for oncologists and patients with cancer. Perthera is not a testing lab. Perthera will facilitate and expedite optimal tissue collection procedures.

The Pancreatic Cancer Action Network created Know Your Tumor to provide pancreatic cancer patients and their oncologists with a precision medicine service that will help guide their treatment. The Pancreatic Cancer Action Network works with Perthera and covers the costs of Perthera's consulting services to coordinate the tumor testing, expert review, and report development.

Permission to Order Molecular Profiling for Patient

Ordering physician hereby provides permission to Personalized Cancer Therapy, Inc. (d.b.a. Perthera) to order appropriate molecular profiling tests and genetic testing (if the patient chooses) on behalf of the physician and patient.

Note: *Molecular profiling tests and medically relevant genetic tests are usually covered by insurance. For more detail regarding the molecular and genetic testing we requisition and insurance reimbursement of these tests, please call 877.827.7893.*

With Patient's Consent, Perthera will order molecular profiling tests for this patient. Perthera will also order genetic testing for patients who choose to have genetic testing performed.

Physician's Signature: _____ Date: _____

Certification of Medical Necessity/Consent

Your signature constitutes a Certificate of Medical Necessity and a certification that you have obtained the patient's consent for Perthera's release of the test results to the patient's third party when necessary as part of the reimbursement process.

Your signature also indicates your understanding that you will receive communication from the Pancreatic Cancer Action Network.