MEDICAL LABS UNLIMITED

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Cancer Genetics Requisition Form

Please submit both pages of this form.

LABORATORY USE ONLY:	DATE RECEIVED:	ACCESSION NO:	SPECIMEN ID:

1. PATIENT INFORMATION (REQUIRED)

First Name_____ Last Name_____
DOB(mm/dd/yyyy) _____ ☐ Male ☐ Female Age_____
Address_____
City_____ State_____ Zip Code _____
Phone _____ Email_____

2. ORDERING PHYSICIAN INFORMATION (REQUIRED)

First Name_____ Last Name_____
Medical Credentials_____ NPI#_____
Facility Name_____
Address_____
City_____ State_____ Zip_____
Direct Office Contact (Required) _____
Phone_____

3. ADDITIONAL RESULTS RECIPIENT

Healthcare Professional Name _____
Phone_____ Fax_____
Email (for notification of results only)_____
Mailing Address_____
City_____ State_____ Zip_____

4. SPECIMEN INFORMATION (REQUIRED)

Date of Collection_____ Collected By_____

Specimen Type ☐ Buccal Swab

5. TEST(S) REQUESTED

Hereditary Cancers

☐ **BRCA1/2 – 2 genes**
Sequencing and duplication/deletion analysis

☐ **Breast and Ovarian Cancer – 15 genes**
ATM, BRCA1, BRCA2, BRIP1, CDH1, MLH1, MSH2, MSH6, PALB2PTEN, RAD51C, RET, STK11, TP53, VHL

☐ **Comprehensive Inherited Cancer Panel – 39 genes** linked to breast, ovarian, colon, pancreatic, and other major cancers
APC, ATM, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, P16(CDKN2A), CHEK2, ELAC2, EPCAM, FANCC, HRAS1, MEN1, MET, MLH1, MRE11a, MSH2, MSH6 MUTYH, NBN, NF1, NTRK1, PALB2, PALLD, PMS2, PTCH1, PTEN, RAD50, RAD51, RAD51C, RAD51D, RET, SMAD4, STK11, TP53, VHL

☐ **Colorectal Cancer Panel - 12 genes**
APC, BMPR1A, CDH1, EPCAM, MLH1, MSH2 MSH6, MUTYH, PMS2, PTEN, SMAD4, STK11

☐ **Lynch Syndrome - 5 genes** Sequencing and duplication/deletion analysis
EPCAM, MLH1, MSH2, MSH6, PMS2

6. ICD10 CODES (REQUIRED)_____

7. MEDICAL NECESSITY / CHART NOTES: Please complete the reverse side of this form and attach clinical notes for medical necessity

8. PATIENT INFORMED CONSENT (Please sign here or the consent form)

☐ I have read the informed Consent Form and give permission to NPL to perform the genetic tests as described.
☐ **Optional**: I consent to use of my de-identified test samples for research.
☐ **Optional**: I am a New York State resident and I consent to storing my test samples at the lab beyond 60 days for future use or testing.

Patient Signature: _____Date:_____

9. CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

The tests ordered are medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine the patient's medical management and treatment decision. The person listed as the Ordering Physician is legally authorized to order the test(s) requested herein. The patient was provided with information about genetic testing and has consented to genetic testing.

Ordering Physician Signature: _____ Date: _____

10. PATIENT PAYMENT OPTIONS

☐ **INSURANCE:** Please attach a copy of front and back of insurance card
☐ **INVOICE PRACTICE / INSTITUITIONAL BILL / FACILITY BILL**
☐ **CREDIT CARD** NPL will contact you for additional information

I am covered by insurance and understand and authorize:

- NPL to give my health insurance plan information on this form and other information provided by my healthcare provider that is necessary for reimbursement.
- NPL to inform my plan of my test result only if required for preauthorization or payment of additional or reflex testing.
- Plan benefits to be payable to NPL.
- NPL to attempt to contact me about my out of pocket responsibility.
- I am responsible for sending NPL all of the money I receive directly from my health plan for this test.

Any genetic testing not performed by this laboratory will be forwarded to another accredited reference laboratory.

Patient Signature: _____Date:_____

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11. ANCESTRY (Select all that apply)

☐ White / Non-Hispanic	☐ Ashkenazi Jewish	☐ Pacific Islander
☐ Hispanic / Latino	☐ Asian	☐ Middle Eastern
☐ Black / African	☐ Native American	☐ Other

12. PATIENT PERSONAL HISTORY OF CANCER & OTHER CLINICAL INFORMATION

☐ Patient has NO personal history of cancer

Patient has been diagnosed with:	Age at Diagnosis	Patient is Currently Being Treated	Pathology and Other Information
☐ Breast Cancer ☐ Left ☐ Right		☐	☐Ductal Invasive ☐ Lobular Invasive ☐DCIS ☐Bilateral ☐Premenopausal ☐ Triple Negative (ER-, PR-, HER2-)
☐ Endometrial/Uterine Cancer		☐	☐Tumor MSI-HIGH or IHC Abnormal Result _____
☐ Ovarian Cancer		☐	☐Non-epithelial
☐ Prostate Cancer		☐	Gleason Score_____
☐ Colon/Rectal Cancer		☐	Type: ☐Mucinous ☐Signet Ring ☐ Medullary Growth Pattern ☐Tumor Infilterating Lymphocytes ☐Crohn's-like Lymphocytic Reaction ☐Patient's tumor is MSI-HIGH or Abnormal Result_____
☐ Colon/Rectal Adenomas		☐	Cumulative Adenomatous Polyp # ☐1 ☐2-5 ☐6-9 ☐10-19 ☐20-99 ☐100+
☐ Hematological Cancer		☐	
☐ Other Cancer		☐	
Check if applicable to patient:	☐ Bone marrow transplant recipient		

13. FAMILY HISTORY OF CANCER

☐ No Known Family History of Cancer ☐ Limited Family Structure

Relationship to Patient	Maternal	Paternal	Cancer Site or Polyp Site	Age at Each Diagnosis
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

14. BREAST CANCER RISK INFORMATION (Only Complete for patients NEVER diagnosed with breast cancer)

Height____ Weight_____
Age at first menstrual period_____
Is Patient: ☐Pre-menopausal ☐ Peri-menopausal
☐Post-menopausal: Age of onset_____
Has this patient has a live birth? ☐No ☐Yes
Age at time of first child's birth____

Has patient ever used Hormone Replacement Therapy? ☐No ☐Yes
If Yes, Treatment Type:
☐ Combined ☐Estrogen Only ☐Progesterone Only
If Yes, is patient a: ☐ Current User: Started_____ yrs ago
Plans to use for ____yrs ☐ Past User: Stopped _____yrs ago

If patient had a breast biopsy, were the results: ☐No Benign Disease
☐Hyperplasia ☐Atypical Hyperplasia ☐LCIS ☐Unknown

Patient's Female Relatives

Number of Daughters_____
Number of Sisters_____
Number of Maternal Aunts__
Number of Paternal Aunts___