



CENTER for PRECISION DIAGNOSTICS

"Powering Precision Medicine"

Pathology and Laboratory Medicine
Clinic Building, K6, Core Lab, E-655
2799 W. Grand Blvd.
Detroit, MI 48202
855.916.4DNA (4362)

HEREDITARY BREAST (BRCA) & OVARIAN MUTATIONS Part I- REQUISITION

Required Patient Information

Ordering Physician Information

Name: _____ Gender: M F

Name: _____

MRN: _____ DOB: MM / DD / YYYY

Address: _____

ICD10 Code(s): _____ / _____ / _____

City: _____ State: _____ Zip: _____

ICD-10 Codes are required for billing. When ordering tests for which reimbursement will be sought, order only those tests that are medically necessary for the diagnosis and treatment of the patient.

Phone: _____ Fax: _____

Billing Information

Patient Demographic/Billing/Insurance Form is required to be submitted with this form. Most genetic testing requires insurance prior authorization. Due to high insurance deductibles and member policy benefits, patients may elect to self-pay. Call for more information (855.916.4362)

- Bill Client or Institution Client Name: _____ Client Code/Number: _____
- Bill Insurance Prior authorization or reference number: _____
- Patient Self-Pay Call for pricing and payment options Toll Free: 855.916.4362

Patient status at time of collection: Inpatient Outpatient

Providers are responsible to obtain informed consent, as required by Michigan law, for predictive or pre-symptomatic genetic tests. Informed Consent for Genetic Testing form is available on our website.

Specimen Submission Requirements

Peripheral blood in lavender (EDTA) top tube (minimum volume: 3 mL) | Specimen Stability: Ambient – 72 hours; Refrigerated – 1 week. **DO NOT FREEZE**
--EXTRACTED DNA ONLY ACCEPTED FROM CLIA CERTIFIED LABORATORIES

BRCA Mutation Testing

All tests include pathologist interpretation at a separate, additional charge.

- BRCA1 and BRCA2 Ashkenazi 3-Mutation Panel** (81212)
Includes next generation sequencing for founder mutations in *BRCA1* (c.68_69delAG and c.5266dupC) and *BRCA2* (c.5946delT) gene
- BRCA1 and BRCA2 Full Gene Sequencing and Common Deletions/Duplications** (81211)
Includes full gene sequencing of *BRCA1/2*, with 5 common deletion/duplication by MLPA
- BRCA1 and BRCA2 Full Gene Sequencing and Full Deletions/Duplications** (81162)
Includes full gene sequencing of *BRCA1* and *2*, with full gene (all exons) deletion/duplication by MLPA
- BRCA1 and BRCA2 Full Deletions/Duplications Only (by MLPA)** (81406)
- 19-Gene Hereditary Breast/Ovarian Cancer-Related Sequence Analysis and Full Deletions/ Duplications** (81432)
Includes full gene sequencing of genes: *ATM, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, FANCC, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53*

Other Known Familial Mutations Needed

Send Additional Report To

Name: _____
Address: _____
Phone #: _____ Fax #: _____



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HEREDITARY BREAST & OVARIAN MUTATION Part II- HISTORY

The information below is required to perform Hereditary Cancer testing.

Required Patient Information

Ordering Physician Information

Name: _____ Gender: M F Name: _____

MRN: _____ DOB: MM / DD / YYYY Contact Number : _____

Patient Ethnicity

- African American
ex: African American, Ethiopian, Haitian, Jamaican, etc.
- Ashkenazi Jewish
- Asian
ex: Asian Indian, Chinese, Filipino, Japanese, Korean, etc.
- Caucasian
ex: English, French, German, Irish, Italian, Polish, etc.
- Hispanic, Latino, or Spanish origin
ex: Colombian, Cuban, Mexican/Mexican American, etc.
- Middle Eastern or North African
ex: Algerian, Egyptian, Iranian, Lebanese, Syrian, etc.
- Native American
ex: Aztec, Inuit, Lakota, Navajo, Mayan, Purhepecha, etc.
- Native Hawaiian or Other Pacific Islander
ex: Chamorro, Fijian, Marshallese, Native Hawaiian, etc.
- Other:

Is this treatable, preventable, or neither? _____

Will the results of the ordered test(s) affect treatment? Yes No

Has there been any genetic counseling? Yes No

Is there a known mutation in the family? Yes No

Specify family member name and relationship

Gene(s): _____ Mutation(s): _____

Include lab report and/or testing facility if possible.

Does the patient have a person history of cancer? Yes No

Specify type(s): _____ Age at Diagnosis: _____

type(s): _____ Age at Diagnosis: _____

Is there a family history of cancer? Yes No

If checked "Yes", please describe in detail below or attach pedigree.



INFORMED CONSENT FOR GENETIC TESTING

PATIENT LAST NAME: (Please Print)		FIRST NAME:	MI:
DATE OF BIRTH: MM/DD/YYYY		PATIENT ID/MRN NUMBER:	
ORDERING PROVIDER INFORMATION (FULL LAST, FIRST): Name: Phone:		GENETIC TESTING REQUESTED FOR: _____ (name of condition)	
<p style="text-align: center;">SAMPLE TYPE</p> <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Blood <input type="checkbox"/> Cheek swab <input type="checkbox"/> Chorionic villus sample (CVS) <input type="checkbox"/> Skin <input type="checkbox"/> Tissue block <input type="checkbox"/> Other _____		<p>The intended purpose is (check all that apply):</p> <input type="checkbox"/> Carrier status <input type="checkbox"/> Diagnostic <input type="checkbox"/> Predictive <input type="checkbox"/> Prenatal <input type="checkbox"/> Pre-symptomatic <input type="checkbox"/> Screening <input type="checkbox"/> Other _____	

1. I have been informed about the nature and the purpose of this genetic test.
2. I have received an explanation of the effectiveness and limitations of this genetic test.
3. I have discussed the benefits and risks of this genetic test with my physician and/or other health care professional. I understand some genetic tests can involve possible medical, psychological or insurance issues for my family and me.
4. I understand the meaning of possible test results and have been informed how I will receive the result.
5. I have been informed that genetic testing can sometimes reveal secondary findings-results that are not related to the purpose of testing. I have discussed with my health care professional if and/or how such results will be shared with me. I understand that it is up to me to decide whether I want secondary results reported back to me and what secondary results I want reported.
6. I have been informed who may have access to my biological sample, and that any leftover sample may be retained by the laboratory.
7. I have been informed who may have access to my genetic test result, which is part of my confidential medical record.
8. My questions have been answered to my satisfaction.
9. I understand that this consent form is intended to be used together with the patient information booklet that contains important information explaining the above eight items. I have read both this consent form and the booklet. I received a copy of the form and booklet for my records.

I consent to have a sample taken for genetic testing on the above-named patient for the condition(s) listed above.

Signature of Patient or Authorized Designee

Date

Circle one: **Self** **Parent(s)** **Legal Guardian** **Durable Power of Attorney for Health Care**

Print Name of Physician or Authorized Delegee explaining the above information:

Signature of Authorized Person:

Date: