

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

Required Patient Information

Name: _____ Gender: M F

MRN: _____ DOB: MM / DD / YYYY

ICD10 Code(s): _____ / _____ / _____

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.

Ordering Physician Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Billing & Collection 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 Collection date: _____ Collection time: _____

Providers are responsible to obtain informed consent, as required by Michigan law, for predictive or pre-symptomatic genetic tests. Informed Consent form is attached to this requisition, please submit with sample.

Specimen/Source

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**

Breast and Ovarian Cancer Testing

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

<p><input type="checkbox"/> BRCA1/BRCA2 Full Gene Sequencing and Full Deletions/Duplications (81162)</p> <p><input type="checkbox"/> Known Familial Variant for BRCA1 (81215)</p> <p><input type="checkbox"/> BRCA1/BRCA2 Ashkenazi 3-Mutation Panel (81212)</p> <p><input type="checkbox"/> Breast Cancer Risk Assessment & Management Panel (11 genes) (81162, 81321, 81323, 81406) <i>Includes sequence analysis and full deletion/duplication BRCA1, BRCA2, CHEK2, ATM, PALB2, TP53, CDH1, PTEN, NF1, NBN, STK11</i></p>	<p><input type="checkbox"/> BRCA1/BRCA2 Full Deletions/Duplications only (81164) <i>(Copy of previous sequencing report required)</i></p> <p><input type="checkbox"/> Known Familial Variant for BRCA2 (81217)</p> <p><input type="checkbox"/> 20-Gene Hereditary Breast/Ovarian Cancer-Related Sequence Analysis (81432, 81433) <i>Includes sequence analysis and full deletion/duplication ATM, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, FANCC, MLH1, MSH2, MSH6, NBN, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53</i></p>
---	---

Other Molecular Testing

Send Additional Report To

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

HEREDITARY BREAST (BRCA) & OVARIAN MUTATIONS

Part II- HISTORY

The information below is required to perform Hereditary Cancer testing.

Required Patient Information

Name: _____ Gender: M F

MRN: _____ DOB: MM / DD / YYYY

Ordering Physician Information

Name: _____

Contact Phone Number : _____

Patient Ethnicity

- | | | |
|---|--|---|
| <input type="checkbox"/> African American
ex: African American, Ethiopian, Haitian, Jamaican

<input type="checkbox"/> Ashkenazi Jewish

<input type="checkbox"/> Asian
ex: Asian Indian, Chinese, Filipino, Japanese, Korean | <input type="checkbox"/> Caucasian
ex: English, French, German, Irish, Italian, Polish

<input type="checkbox"/> Hispanic, Latino, or Spanish origin
ex: Colombian, Cuban, Mexican/Mexican American

<input type="checkbox"/> Middle Eastern or North African
ex: Algerian, Egyptian, Iranian, Lebanese, Syrian | <input type="checkbox"/> Native American
ex: Aztec, Inuit, Lakota, Navajo, Mayan, Purhepecha

<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
ex: Chamorro, Fijian, Marshallese, Native Hawaiian

<input type="checkbox"/> 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 personal 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: <hr style="width:80%; margin: 0 auto;"/> <p style="text-align: center;">(name of condition)</p>	
<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 _____	The intended purpose is (check all that apply): <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 this consent form and understand that I can access the booklet electronically at: https://www.michigan.gov/documents/InformedConsent_69182_7.pdf
10. I received a copy of this form 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: _____