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 CANCER PANELS
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 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*

Hereditary Cancer Panels

All tests include pathologist interpretation at a separate, additional charge

NGS and Full Deletions/ Duplications – (May require prior Genetic counseling)

☐ **Hereditary Colorectal/ HNPCC Cancer Risk Panel (15 genes):** *APC, ATM, BMPR1A, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, SMAD4, STK11, TP53* (81435)

☐ **Hereditary Endometrial Cancer Risk Panel (18 genes):** *ATM, BRCA1, BRCA2, CHEK2, CDH1, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, STK11, TP53, BRIP1, NBN, PALB2, RAD51C* (81321, 81317, 81292 and 81298)

☐ **Hereditary Familial Cutaneous Melanoma Risk Panel (2 genes):** *CDK4, CDKN2A* (81403, 81404)

☐ **Hereditary Neuroendocrine Tumor Disorders Risk Panel (13 genes):** *FH, MAX, MEN1, NF1, RET, SDHAF2, SDHB, SDHC, SDHD, TMEM127, TSC1, TSC2, VHL* (81437)

☐ **94 Gene Comprehensive Panel:** Includes all genes listed below (Call for CPT coding)

Customized Hereditary Cancer Risk Panel (CPT codes vary by gene. Contact us for pricing on your custom panel)

☐ AIP	☐ BRCA2	☐ CEBPA	☐ EPCAM	☐ FANCA	☐ FANCL	☐ KIT	☐ NBN	☐ PRF1	☐ RET	☐ SLX4	☐ TSC2
☐ ALK	☐ BRIP1	☐ CEP57	☐ ERCC2	☐ FANCB	☐ FANCM	☐ MAX	☐ NF1	☐ PRKAR1A	☐ RHBDF2	☐ SMAD4	☐ VHL
☐ APC	☐ BUB1B	☐ CHEK2	☐ ERCC3	☐ FANCC	☐ FH	☐ MEN1	☐ NF2	☐ PTCH1	☐ RUNX1	☐ SMARCB1	☐ WRN
☐ ATM	☐ CDC73	☐ CYLD	☐ ERCC4	☐ FANCD2	☐ FLCN	☐ MET	☐ NSD1	☐ PTEN	☐ SBDS	☐ STK11	☐ WT1
☐ BAP1	☐ CDH1	☐ DDB2	☐ ERCC5	☐ FANCE	☐ GATA2	☐ MLH1	☐ PALB2	☐ RAD51C	☐ SDHAF2	☐ SUFU	☐ XPA
☐ BLM	☐ CDK4	☐ DICER1	☐ EXT1	☐ FANCF	☐ GPC3	☐ MSH2	☐ PHOX2B	☐ RAD51D	☐ SDHB	☐ TMEM127	☐ XPC
☐ BMPR1A	☐ CDKN1C	☐ DIS3L2	☐ EXT2	☐ FANCG	☐ HNF1A	☐ MSH6	☐ PMS1	☐ RB1	☐ SDHC	☐ TP53	
☐ BRCA1	☐ CDKN2A	☐ EGFR	☐ EZH2	☐ FANCI	☐ HRAS	☐ MUTYH	☐ PMS2	☐ RECQL4	☐ SDHD	☐ TSC1	

Other Molecular DNA/RNA Tests

Send Additional Report To

Name:

Address:

Phone #: Fax #:

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 CANCER PANELS
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 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.

Henry Ford Health System

CENTER for PRECISION DIAGNOSTICS

"Powering Precision Medicine"

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) The intended purpose is (check all that apply): ☐ Carrier status ☐ Diagnostic ☐ Predictive ☐ Prenatal ☐ Pre-symptomatic ☐ Screening ☐ Other_____	
SAMPLE TYPE ☐ Amniotic fluid ☐ Blood ☐ Cheek swab ☐ Chorionic villus sample (CVS) ☐ Skin ☐ Tissue block ☐ 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:

This consent form was developed by the Michigan Department of Health and Human Services in compliance with PA 29 of 2000 and must be distributed with "Informed Consent for Genetic Testing" patient booklet. Neither may be altered or deleted to change the meaning of specific statements above or the intent of the informed consent process.

Revised 08/15