313.916.4DNA (4362)
Toll Free: 855.916.4DNA
Fax: 313.916.7071
www.henryford.com/hfcpd

HENRY FORD CENTER FOR PRECISION DIAGNOSTICS

Ship specimens to:
Henry Ford Center for Precision Diagnostics
Henry Ford Hospital
Pathology and Laboratory Medicine
Clinic Building, K6, Core Lab, E-655
2799 W. Grand Blvd. | Detroit, MI 48202

HEREDITARY CANCER GENETIC RISK TESTING FORM

Part I

Please submit Clinical History Form (Part IIA or B)

Required Patient Information

Name: _____ Gender: M F

MRN: _____ DOB: MM / DD / YY

Insurance Authorization #: _____

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.

Specimen Collection Date: _____

ICD10 Code(s): _____ / _____ / _____

Ordering Physician Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Genetic Counselor: _____

Genetic Counselor Phone #: _____

Clinical Diagnosis: _____

This request to order tests from HFCPD certifies to HFCPD that (1) the ordering physician has obtained written informed consent from the patient as required by applicable state or federal laws for each test ordered and (2) the ordering physician has authorization from the patient permitting HFCPD to report results for each test ordered to the ordering physician.

I have been counseled on the risks and benefits of this testing and give my consent for this testing. Patient Signature: _____

I certify that this testing is medically necessary. Clinician Signature: _____

All tests include pathologist interpretation at a separate charge (G0452)

Specimens Submission Requirements:

Peripheral blood in lavender top tube (EDTA)	Minimum Volume Requirements: 3 mL
Specimen Stability: Ambient – 72 hours; Refrigerated – 1 week.	Reasons for Rejection: Frozen specimen

Submit Part IIA with this request.

BRCA Mutation Testing

- ❑ **BRCA1 and BRCA2 (BReast CAncer genes 1 and 2) Sequencing and Common Deletions/ Duplications** (CPT 81211) – 1st Tier Testing: includes full gene sequencing of BRCA1/2, with 5 common deletion/duplication by MLPA
- ❑ **BRCA1 and BRCA2 (BReast CAncer genes 1 and 2) Sequencing and Full Deletions/ Duplications** (CPT 81162) – 2nd Tier Comprehensive Testing: includes full gene sequencing of BRCA1 and 2, with full gene (all exons) deletion/duplication by MLPA
- ❑ **BRCA1 and BRCA2 (BReast CAncer genes 1 and 2) Full Deletion/ Duplication by MLPA** (CPT 81406)
- ❑ **Hereditary Breast/ Ovarian Cancer-Related Gene Sequence Analysis (19 genes) and Full Deletions/ Duplications** (CPT 81432) – Tier 3 Testing: includes full gene sequencing of the following: *ATM, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, FANCC, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53* – Testing DOES NOT include deletion/duplication analysis.
- ❑ **Other Deletions / Duplications**: _____

Submit Part IIB with this request.

Additional Hereditary Cancer Risk Mutation Testing – (May require prior Genetic counseling)

- ❑ **Hereditary Colorectal/ HNPCC Cancer Risk Panel (15 genes) and Full Deletions/ Duplications** (CPT 81435): *APC, ATM, BMPR1A, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, SMAD4, STK11, TP53*
- ❑ **Hereditary Endometrial Cancer Risk Panel (18 genes) and Full Deletions/ Duplications** (CPT 81321, 81317, 81292 and 81298): *ATM, BRCA1, BRCA2, CHEK2, CDH1, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, STK11, TP53, BRIP1, NBN, PALB2, RAD51C*
- ❑ **Hereditary Familial Cutaneous Melanoma Risk Panel (2 genes) and Full Deletions/ Duplications** (CPT 81403, 81404): *CDK4, CDKN2A*
- ❑ **Hereditary Neuroendocrine Tumor Disorders Risk Panel (13 genes) and Full Deletions/ Duplications** (CPT 81437): *FH, MAX, MEN1, NF1, RET, SDHAF2, SDHB, SDHC, SDHD, TMEM127, TSC1, TSC2, VHL*

Submit Part IIB with this request.

Customized Hereditary Cancer Testing (single or multi-gene panel, please specify). CPT codes vary by gene. Contact us for pricing on your custom panel.

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

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CLINICAL HISTORY FOR HEREDITARY BREAST CANCER (HBOC) TESTING
Part IIA

THIS IS NOT A TEST REQUEST FORM

The information below is required to perform hereditary cancer testing. Please complete this form to the best of your ability and submit together with the Hereditary Cancer Genetic Risk Testing form (Part I).

Required Patient Information

Name: _____ Gender: M F

MRN: _____ DOB: MM / DD / YY

Insurance Authorization #: _____

Patient's primary language if not English: _____

Patient's Contact Number: _____

Patient's email Address: _____

Ordering Physician Information

Name: _____

Address: _____

Physician's Specialty: _____

Physician's Signature: _____

Genetic Counselor: _____

Genetic Counselor Phone #: _____

Patient's ETHNICITY (check all that apply)

- ❑ 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 there a known mutation in the family? ❑ Yes ❑ No

Specify family member name and relationship

Gene: _____ Mutation: _____

Include lab report and/or testing facility if possible.

Is there a personal history of cancer in the patient? ❑ Yes ❑ No

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

type(s): _____ Age at Diagnosis: _____

Is there a personal or family history of the following HBOC cancer types?

Please check all that apply:

- ❑ Breast
  - ❑ Bilateral ❑ Lateral
  - ❑ Triple negative
- ❑ Ovarian
  - ❑ Bilateral ❑ Lateral
- ❑ Fallopian
  - ❑ Bilateral ❑ Lateral
- ❑ Uterine
- ❑ Pancreatic
- ❑ Prostate (Gleason >7)
- ❑ Skin (melanoma)
- ❑ Diffuse Gastric
- ❑ Adrenal Cancer
- ❑ Sarcoma
- ❑ Brain tumor
- ❑ Leukemia
- ❑ Thyroid Cancer
- ❑ Kidney Cancer
- ❑ Colon Cancer
- ❑ Other: _____

For each cancer type checked, please specify:

Cancer Type	Relationship	Age at Diagnosis

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CLINICAL HISTORY FOR HEREDITARY CANCER TESTING
Part IIB

THIS IS NOT A TEST REQUEST FORM

The information below is required to perform hereditary cancer testing. Please complete this form to the best of your ability and submit together with the Hereditary Cancer Genetic Risk Testing form (Part I).

Required Patient Information

Name: _____ Gender: M F

MRN: _____ DOB: MM / DD / YY

Insurance Authorization #: _____

Patient's primary language if not English: _____

Patient's Contact Number: _____

Patient's email Address: _____

Ordering Physician Information

Name: _____

Address: _____

Physician's Specialty: _____

Physician's Signature: _____

Genetic Counselor: _____

Genetic Counselor Phone #: _____

Patient's ETHNICITY (check all that apply)

- ❑ 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 there a known mutation in the family? ❑ Yes ❑ No

Specify family member name and relationship

Gene: _____ Mutation: _____

Include lab report and/or testing facility if possible.

Is there a personal history of cancer in the patient? ❑ Yes ❑ No

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

type(s): _____ Age at Diagnosis: _____

Is there a personal or family history of the following cancer types?

Please check all that apply:

- ❑ Colorectal
  - ❑ Lynch (MSI)
  - ❑ Other: _____
- ❑ Breast
  - ❑ Bilateral ❑ Lateral
- ❑ Ovarian
  - ❑ Bilateral ❑ Lateral
- ❑ Endometrial
- ❑ Pancreatic
- ❑ Prostate
- ❑ Leukemia
- ❑ Diffuse Gastric
- ❑ Adrenal Cancer
- ❑ Medullary thyroid
- ❑ Nonmedullary thyroid
- ❑ Parathyroid
- ❑ Pheochromocytoma
- ❑ Pituitary Cancer
- ❑ Kidney Cancer
- ❑ Other: _____

For each cancer type checked, please specify:

Cancer Type	Relationship	Age at Diagnosis