CIRCULOGENE

RECEIVED DATE _____ RECEIVED BY _____

REV 6/18/2020

Client Services: 855-380-1555 Fax: 855-614-7084
1555 Palm Beach Lakes Blvd., Suite 830
West Palm Beach, FL 33401
Ship to: 3125 Independence Drive, Suite 301, Birmingham, AL 35209
support@circulogene.com

Hereditary

1. PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

MR# _____

DOB _____ ☐ MALE ☐ FEMALE

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PRIMARY PHONE _____

2. SPECIMEN INFORMATION*

COLLECTION DATE ___/___/___ COLLECTION TIME _____ ☐ AM ☐ PM

*FOR TISSUE OR OTHER SPECIMEN TYPE, CONTACT CIRCULOGENE FOR APPROPRIATE REQUISITION FORMS.

3. DIAGNOSIS INFORMATION

DIAGNOSIS _____ ICD-10 CODE(S) _____

TREATMENT STATUS: ☐ PRE ☐ POST DISEASE STAGE: ☐ I-II ☐ III ☐ IV

4. CLIENT INFORMATION / ORDERING PHYSICIAN

CLIENT ID _____ NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____

INDICATE ORDERING PHYSICIAN: _____

☐ OTHER _____ IF OTHER, NPI #_____

5. BILLING INFORMATION **INCLUDE COPY OF INSURANCE CARD & I.D.**

☐ ATTACH FACE SHEET WITH PATIENT INSURANCE INFORMATION
OR COMPLETE INSURANCE INFORMATION ON BACK OF THIS FORM

☐ ATTACH COPY FRONT AND BACK OF INSURANCE CARD(S) IF POSSIBLE

HEREDITARY PANELS:

BRCA PANEL
☐ BRCA1
BRCA2

INHERITED BREAST/ OVARIAN/UTERINE CANCER PANEL
☐ ATM, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53

INHERITED COLORECTAL CANCER PANEL
☐ APC, ATM, BMPR1A, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53

LYNCH SYNDROME PANEL
☐ MLH1, MSH2, MSH6, PMS2, EPCAM

INHERITED PANCREATIC CANCER PANEL
☐ APC, ATM, BRCA1, BRCA2, CDKN2A, EPCMA, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53

INHERITED PROSTATE CANCER PANEL
☐ ATM, BRCA1, BRCA2, CHEK2, PALB2, RAD51D, TP53, MLH1, MSH2, MSH6, PMS2, EPCAM

INHERITED COMPREHENSIVE CANCER PANEL
☐ APC, ATM, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, PALB2, PMS2, POLD1, POLE, PTEN, RAD51C, RAD51D, SMAD4, STK11, TP53, VHL

FH PANEL
☐ APOB, LDLR, PCSK9, LDLRAP1

TO ORDER INDIVIDUAL GENES:
PLEASE COMPLETE: _____

☐ Reflex to FFPE tissue testing if negative for mutations in the blood. By checking this box, CIRCULOGENE will contact your office to collect tissue for testing. Please contact the following to obtain tissue sample: Institution/facility name (place where blocks are held) _____

CONTACT NAME _____ PHONE NUMBER _____ FAX NUMBER _____

AUTHORIZING SIGNATURE REQUIRED

This requisition constitutes a certification of medical necessity and intent to use the results of test(s) ordered. All of the information on this form is true and correct. We have obtained patient informed consent* and authorize CIRCULOGENE to release the results and patient information for reimbursement purposes. To the best of my knowledge, I certify that (if ordered) this patient qualifies for applicable hereditary testing.

*CIRCULOGENE can provide a Patient Genetic Testing Consent form and a Hereditary Cancer Screening Questionnaire if requested.

SIGNATURE _____ DATE _____

BILLING INFORMATION

INCLUDE COPY OF INSURANCE CARD & I.D.

SPECIMEN ORIGIN (MUST CHOOSE 1): _____

☐ NON-HOSPITAL PATIENT ☐ HOSPITAL PATIENT (IN) ☐ HOSPITAL PATIENT (OUT)

PAYMENT OPTIONS: _____

BILL TO: ☐ INSURANCE ☐ PATIENT/SELF PAY ☐ BILL CHARGES TO OTHER HOSPITAL/FACILITY:

☐ MEDICARE ☐ MEDICAID ☐ CLIENT BILL _____

PRIOR AUTHORIZATION# (IF AVAIL): _____

PRIMARY INSURANCE _____

CARRIER

POLICY # GROUP #

SUBSCRIBER DOB

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD

SECONDARY INSURANCE _____

CARRIER

POLICY # GROUP #

SUBSCRIBER DOB

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD

CREDIT CARD NUMBER SEC. CODE

NAME ON CARD EXPIRATION DATE

SPECIMEN REQUIREMENTS AND PROCEDURES

- Standard lavender sample tube
- Volume 4mL of whole blood
- Gently invert tube 5 times
- Refrigerate immediately after inverting (do not freeze)
- Specimen viability is 7 days NOT including collection date (if kept refrigerated)
- Tube must include one label, patient name, date of birth, and phlebotomist signature
- Apply label correctly
- Follow packing instructions on shipper box when ready to ship. Keep refrigerated until ready to ship.

FAMILY HISTORY

- ☐ Family history of Breast Cancer
- ☐ Family history of Ovarian/Fallopian Tube/Primary Peritoneal Cancer
- ☐ Family history of Colorectal Cancer
- ☐ Family history of Pancreatic Cancer
- ☐ Family history of Prostate Cancer
- ☐ Close relative with a known Hereditary Cancer Syndrome (gene mutation)
- ☐ Other:_____

Relationship to Patient	(M) Maternal/ (P) Paternal	Cancer Site or Polyp Type (Add # for colon/rectal adenomas)	Age at Diagnosis

HEREDITARY GENES

[1]HBOUC PANEL* [2]COLORECTAL CANCER PANEL
[3]PANCREATIC CANCER PANEL [4]PROSTATE CANCER PANEL
[5]LYNCH SYNDROME

APC[2,3]	CHEK2[1,2,4]	POLE[2]
ATM[1,2,3,4]	EPCAM[1,2,3,4,5]	PTEN[1,2]
BMPR1A[2]	MLH1[1,2,3,4,5]	RAD51C[1]
BRCA1[1,3,4]	MSH2[1,2,3,4,5]	RAD51D[1,4]
BRCA2[1,3,4]	MSH6[1,2,3,4,5]	SMAD4[2]
BRIP1[1]	MUTYH[2]	STK11[1,2,3]
CDK4	PALB2[1,3,4]	TP53[1,2,3,4]
CDH1[1,2]	PMS2[1,2,3,4,5]	VHL
CDKN2A[3]	POLD1[2]	

*Hereditary Breast/Ovarian/Uterine Cancer Panel
Full gene list available at www.circulogene.com

CIRCULOGENE