

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 _____ / _____ / _____ AM PM

COLLECTION TIME _____

*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:

| | | | | |
|--|--|--|--|---|
| <p>BRCA PANEL</p> <p><input type="checkbox"/> BRCA1 <input type="checkbox"/> BRCA2</p> | <p>INHERITED BREAST/OVARIAN/UTERINE CANCER PANEL</p> <p><input type="checkbox"/> ATM, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53</p> | <p>INHERITED COLORECTAL CANCER PANEL</p> <p><input type="checkbox"/> APC, ATM, BMPRIA, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53</p> | <p>LYNCH SYNDROME PANEL</p> <p><input type="checkbox"/> MLH1, MSH2, MSH6, PMS2, EPCAM</p> | <p>INHERITED PANCREATIC CANCER PANEL</p> <p><input type="checkbox"/> APC, ATM, BRCA1, BRCA2, CDKN2A, EPCMA, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53</p> |
| <p>INHERITED PROSTATE CANCER PANEL</p> <p><input type="checkbox"/> ATM, BRCA1, BRCA2, CHEK2, PALB2, RAD51D, TP53, MLH1, MSH2, MSH6, PMS2, EPCAM</p> | <p>INHERITED COMPREHENSIVE CANCER PANEL</p> <p><input type="checkbox"/> APC, ATM, BMPRIA, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, PALB2, PMS2, POLD1, POLE, PTEN, RAD51C, RAD51D, SMAD4, STK11, TP53, VHL</p> | <p>FH PANEL</p> <p><input type="checkbox"/> APOB, LDLR, PCSK9, LDLRAP1</p> | <p>TO ORDER INDIVIDUAL GENES:</p> <p>PLEASE COMPLETE: _____</p> | |

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 10mL 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 |
|-------------------------|-------------------------------|--|------------------|
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HEREDITARY GENES

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

| | | |
|------------------------|----------------------------|-------------------------|
| APC ^{2,3} | CHEK2 ^{1,2,4} | POLE ² |
| ATM ^{1,2,3,4} | EPCAM ^{1,2,3,4,5} | PTEN ^{1,2} |
| BMPRIA 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**