Integrated GENETICS
LabCorp Specialty Testing Group

HEREDITARY CANCER TEST REQUISITION

Highlighted fields are required.

Patient Information

Name
Last First MI

☐ Male ☐ Female Date of Birth / /

Address

Home Phone Work Phone

City State Zip

Lab # Hospital #

Client Information

I attest that this patient has been informed about and has given consent for the test(s) I have ordered below under applicable law.

Referring Physician (print):

Physician/Authorized Signature:

Genetic Counselor (print):

NPI#: Taxonomy#:

Date drawn: / / **Specimen Type:** ☐ Peripheral Blood ☐ Saliva

Ethnicities (Check all that apply):

☐ Caucasian ☐ Ashkenazi Jewish ☐ Sephardic Jewish ☐ Asian
☐ African American ☐ Native American ☐ Hispanic
☐ Other: _____

Hereditary Breast and Ovarian Cancer (test components on back)

☐ BRCA*ssure*®: Comprehensive Analysis
☐ BRCA*ssure*®: *BRCA1* Targeted Analysis*
☐ BRCA*ssure*®: *BRCA2* Targeted Analysis*
☐ BRCA*ssure*®: Ashkenazi Jewish Panel
☐ BRCA*ssure*®: *BRCA1/2* Deletion/ Duplication Analysis

*Known familial variants. Copy of family member's results required.

Hereditary Cancer Panels (Genes included listed on back)

☐ VistaSeq® Hereditary Cancer Panel (27 Gene Assay)
☐ VistaSeq® Hereditary Cancer Panel without *BRCA1/2* genes (25 Gene Assay)
☐ VistaSeq® Breast Cancer Panel (19 Gene Assay)
☐ VistaSeq® High/Moderate Risk Breast Cancer Panel (9 Gene Assay)
☐ VistaSeq® GYN Cancer Panel (11 Gene Assay)
☐ VistaSeq® Breast and GYN Cancer Panel (25 Gene Assay)

☐ Other VistaSeq Panel _____

☐ Mutation Specific Sequencing Mutation(s): _____

Patient Clinical Cancer History

☐ No personal history of cancer
☐ Breast, Invasive or DCIS, age at Dx_____ (Check all that apply)
☐ Bilateral ☐ Premenopausal ☐ Triple Negative (ER-, PR-, HER-)
☐ Ovarian, Age at Dx_____ ☐ Endometrial, Age at Dx_____
☐ Pancreatic, Age at Dx_____ ☐ Renal, Age at Dx____
☐ Prostate, Age at Dx _____ If Prostate Gleason Score _____
☐ Colorectal, Age at Dx_____
MSI Result: ☐ High ☐ Stable ☐ Low
IHC Result: ☐ Present ☐ Absent IHC of _____
☐ Other Cancers, _____Age(s) of Dx: _____
☐ History of Bone Marrow / Stem Cell Transplant
☐ History of blood transfusion, date of last transfusion_____
Has the patient had genetic testing for cancer? If yes, attach report

When ordering tests for which Medicare or Medicaid reimbursements will be sought, physicians should order only those test that are medically necessary for the diagnosis or treatment of the patient.

CLINICAL INDICATION FOR TEST

All diagnoses should be provided by the ordering physician or an authorized designee. Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required)

ICD-CM		ICD-CM		ICD-CM	

Family History

Is there a family history of cancer? ☐ Yes ☐ No ☐ Unknown
Have any family members tested positive for a hereditary cancer syndrome? ☐ Yes ☐ No
If Yes, Type _____
Please attach a copy of the results
Is the patient adopted? ☐ Yes ☐ No
Please attach pedigree or complete table below. Is a pedigree attached? ☐ Yes ☐ No

Relative (Father, Sister, Aunt, etc.)	Maternal or Paternal	Relative Available for Testing? If no, state reason	Cancer Type	Age at Diagnosis

Genetic counseling provided: ☐ Yes ☐ No
If yes, provide counselor name: _____
Phone Number:_____

Patient understands by signing below:

LabCorp may use information obtained on this form and other information provided by me and/or my ordering provider or his/her designee to initiate prior authorization with my health plan as required. I understand a prior authorization approval from my health plan does not guarantee full payment.

LabCorp will attempt to contact me if my estimated out-of-pocket payment is more than $300. Testing may be canceled if LabCorp is unable to reach me. No matter my estimated cost, my actual out-of-pocket cost may be higher or lower than the estimate provided. It is my responsibility to contact my health plan regarding concerns over my coverage and benefits.

☐ In the event I cannot be reached, LabCorp may leave a confidential voicemail message related to testing at the telephone number provided below.

Patient's Signature (required) _____ **Telephone** _____

BILLING INFORMATION

Patient Hospital Status: ☐ Inpatient ☐ Outpatient ☐ Non-hospital
☐ Medicaid ☐ Medicare ☐ Insurance ☐ Client Bill ☐ CA XAFP ☐ Self-Pay
☐ Billing Information Attached (Please include a copy of insurance card or face sheet.)
Do not attach credit card information to this form for security purposes.
Insurance Company Name _____
Policy # _____ Group # _____
Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Patient Signature _____ Date: _____

LABORATORY USE ONLY

By signing this form, I hereby authorize Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to LCAH.
I understand that I am responsible for any amounts not paid by insurance for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.

BRCA*ssure*®				
Comprehensive *BRCA1/2* Analysis Includes full gene sequencing and, duplication/deletion analysis of *BRCA1/2* genes	**_BRCA1_ Targeted Sequencing** Includes squencing of know familial mutation(s) on *BRCA1* gene	**_BRCA2_ Targeted Sequencing** Includes squencing of know familial mutation(s) on *BRCA2* gene	**Ashkenazi Jewish *BRCA* Panel** Includes screening for three know pathogenic variants: two in *BRCA1* gene, one in *BRCA2* gene	**BRCAssure®: *BRCA1/2* Deletion/duplication analysis** Deletion/duplication analysis of *BRCA1/2* genes

Hereditary Cancer Panel Gene Lists

VistaSeq® Hereditary Cancer Panel

APC	CDH1	MSH2	PTEN
ATM	CDK4	MSH6	RAD51C
BARD1	CDKN2A	MUTYH	RAD51D
BMPR1A	CHEK2	NBN	SMAD4
BRCA1*	EPCAM	PALB2	STK11
BRCA2*	FAM175A	PMS2	TP53
BRIP1	MLH1	PRKAR1A	

* Not included in VistaSeq Hereditary Cancer Panel without BRCA1/2 genes

VistaSeq® Breast Panel

ATM	FAM175A	RAD50
BARD1	MRE11A	RAD51C
BRCA1	MUTYH	RAD51D
BRCA2	NBN	STK11
BRIP1	NF1	TP53
CDH1	PALB2	
CHEK2	PTEN	

VistaSeq® High/Moderate Risk Breast Panel

ATM	PALB2
BRCA1	PTEN
BRCA2	STK11
CDH1	TP53
CHEK2	

VistaSeq® GYN Panel

BRCA1	MLH1	PMS2
BRCA2	MSH2	PTEN
CHEK2	MSH6	TP53
EPCAM	MUTYH	

VistaSeq® Breast and GYN Panel

ATM	EPCAM	MUTYH	RAD51C
BARD1	FAM175A	NBN	RAD51D
BRCA1	FANCC	NF1	STK11
BRCA2	MLH1	PALB2	TP53
BRIP1	MRE11A	PMS2	
CDH1	MSH2	PTEN	
CHEK2	MSH6	RAD50	

B1A

gen-248-V6-04292019