PsiGenex™

(888) 530-2239
(201) 573-0719
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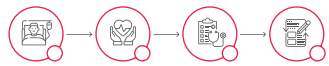
www.psigenex.com

Include these items



Hereditary Cancer Screening Test Requisition

Patient Information (Fill or attach EMR records)

First Name_____ Last Name_____
Biological Sex ☐ Male ☐ Female DOB_____/_____/_____
Medical Record Number_____
Street Address_____
City_____ State and Zip code_____
Email Address_____
Phone Number_____

Ordering Provider

Full Name_____
Phone_____ Fax_____

Clinical Indications

Ethnicity

☐ Asian
☐ Black/African American
☐ Pacific Islander
☐ French Canadian
☐ White/Caucasian
☐ Ashkenazi Jewish
☐ Sephardic Jewish
☐ Middle Eastern
☐ Hispanic/Latin American
☐ Native American
☐ Other _____

☐ **The patient has family history of cancer**

Known family history of genetic mutations? ☐ Yes (Attach copy of report) ☐ No

Family Cancer Type	Age of Dx	Relationship	Relative available for testing?
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

☐ **The patient has personal history of cancer**

Cancer	Notes/Criteria	Age of Diagnosis
☐ Breast	☐ Triple negative (ER-, PR-, HER2-)	_____
☐ Ovarian/Fallopian	☐ Non-epithelial	_____
☐ Uterine / Endometrial	☐ Tumor MSI-high or IHC abnormal	_____
☐ Prostate	☐ Gleason Score ≥ 7	_____
☐ Pancreatic		_____
☐ Stomach		_____
☐ Colorectal		_____
☐ Melanoma		_____
☐ Lung		_____
☐ Other(s)_____		_____

Testing Options

☐ **Comprehensive Hereditary Cancer Panel**

Our proprietary comprehensive hereditary cancer panel covers more than 9 different organ systems, as well as more than 32 hereditary cancer syndromes. This panel tests 54 genes, including *BRCA1*, *BRCA2*, and other guideline-recommended high-penetrance genes, as well as the most common hereditary cancer-related genes.

☐ **BRCA1 and BRCA2 Panel**

Full gene sequencing analysis plus full duplication analysis.
BRCA1 and *BRCA2* only.

Organ and System Specific Panels

(Only genes relevant to the selected organ or system will be reported)

☐ **Hereditary Breast Cancer Panel**
☐ **Hereditary Colorectal Cancer Panel**
☐ **Hereditary Endometrial Cancer Panel**
☐ **Hereditary Gastric Cancer Panel**
☐ **Hereditary Melanoma Panel**
☐ **Hereditary Ovarian Cancer Panel**
☐ **Hereditary Pancreatic Cancer Panel**
☐ **Hereditary Prostate Cancer Panel**

(see back for full list of genes covered in each panel)

Specimen Information

Specimen type ☐ Blood ☐ Saliva
Collection Date_____/_____/_____ Send Date_____/_____/_____
Bone marrow transplant recipient? ☐ Yes ☐ No

Reporting Options

☐ Exclude VUS (Report only pathogenic or likely pathogenic variants) ☐ Rush/STAT

Billing Information

☐ Institutional Billing (Send invoice to facility above)
☐ Patient Billing Credit Card #_____ Expiration_____/_____
☐ Insurance Billing
Insurance Company Name_____
Address_____
Policy Holder Name_____
Policy Holder Relationship to Patient_____
Policy Number_____
Prior Auth #_____

ICD-10 (Diagnosis Codes)

☐ Z85.03 - Personal history of malignant neoplasm of breast
☐ Z80.03 - Family history of malignant neoplasm of breast
☐ Z85.43 - Personal history of malignant neoplasm of ovary
☐ Z80.41 - Family history of malignant neoplasm of ovary
☐ Z85.42 - Personal history of malignant neoplasm of other part of uterus
☐ Z80.49 - Family history of malignant neoplasm of other genital organs
☐ Z80.08 - Family history of malignant neoplasm of other organ
☐ Other _____

Physician Acknowledgment

Confirmation of Informed Consent & Statement of Medical Necessity

I affirm each of the following: I have provided genetic testing information to the patient and the patient has consented to genetic testing. This test is medically necessary, and the results will be used in the patient's medical management and treatment decisions. The person listed as the Ordering Provider is authorized by law to order the test(s) requested herein.

Provider's Signature _____ Date____/____/_____

Patient Acknowledgment

I have read the attached Informed Consent document. I give permission to PsiGenex to perform genetic testing as described. I also give PsiGenex permission to share any relevant personal information with my insurance company for billing purposes. I authorize PsiGenex to bill my insurance company for testing. I understand the benefits and limitations of PGT-A.

Patient's Signature _____ Date____/____/_____

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Gene list

Gene List	Comprehensive Panel	Breast Panel	Ovarian Panel	Colorectal Panel	Endometrial Panel	Melanoma Panel	Pancreatic Panel	Gastric Panel	Prostate Panel
APC	•			•			•	•	
ATM	•	•					•		•
AXIN2	•			•					
BAP1	•					•			
BARD1	•	•	•						
BMPR1A	•			•			•	•	
BRCA1	•	•	•		•		•	•	•
BRCA2	•	•	•		•	•	•	•	•
BRIP1	•	•	•						
CDH1	•	•	•	•				•	
CDK4	•					•	•		
CDKN2A	•					•	•		
CHEK2	•	•	•		•				•
CTNNA1	•							•	
DICER1	•		•						
EPCAM	•		•		•		•	•	•
GALNT12	•			•					
GREM1	•			•					
HOXB13	•								•
KIT	•							•	
MEN1	•						•	•	
MITF	•					•			
MLH1	•		•	•	•		•	•	•
MRE11A	•	•	•						
MSH2	•		•	•	•		•	•	•
MSH3	•			•					
MSH6	•		•		•		•	•	•
MUTYH	•	•		•	•			•	
NBN	•	•	•						•
NF1	•	•					•	•	
NTHL1	•								
PALB2	•	•	•				•		•
PDGFRA	•							•	
PMS2	•		•	•	•		•	•	•
POLD1	•			•	•				
POLE	•			•					
PTEN	•	•		•	•	•			
RAD50	•	•	•						
RAD51C	•	•	•						
RAD51D	•	•	•						•
RET	•								
RNF43	•			•					
RPS20	•								
SDHA	•							•	
SDHB	•							•	
SDHC	•							•	
SDHD	•							•	
SMAD4	•			•			•	•	
SMARCA4	•		•						
STK11	•	•	•		•		•	•	
TP53	•	•	•	•	•	•	•	•	•
TSC1	•						•		
TSC2	•						•		
VHL	•						•		

COLLEGE of AMERICAN PATHOLOGISTS

Clinical Laboratory Improvements Amendments