A DIVISION OF GENESIS CLINICAL DIAGNOSTICS
A MEMBER OF GENESIS BIOTECHNOLOGY GROUP

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CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS

Variant of Uncertain Significance (VUS) Test Requisition Form

Ordering Physician/Laboratory

(Required: Include the ordering physician's first & last name, NPI, practice name, complete address, phone number and fax number.)

Physician to receive additional result report:

Physician's Signature: | Date:

Genetic Testing Specimen Information

Date Collected (Req.): | Specimen Source: ☐ Blood ☐ Saliva

Test Selection - Blood or Saliva

ICD10 codes (Req.):

1224 Gene Specific Site Analysis:

Specify Gene: _____

Variant (mutation):_____

Information from Family Member's Previous Testing:

Please attach the original family member's clinical report or provide the MDL# and information below:

Family Member MDL #: _____

Relationship to Family Member: _____

Gene(s): _____

Variant(s): _____

Confirmation of Consent for Genetic Testing

My signature below certifies that I have read and fully understand this test requisition form and acknowledge that I consent to testing for MDL's VUS Resolution Program. I understand that this is a voluntary program with no additional charge for selected family members of patients previously tested by MDL. Participation in this program may not result in an immediate reclassification and interpretation of the VUS variant to be tested. However, reclassification can still occur at a later date after multiple families with the variant are tested. Not all variants can be resolved through this program. I understand that if a variant is reclassified, an amended report with the new interpretation will be reported to me only and not to any health-care provider or any other third-party.

_____ _____

Patient Signature (Required) | Date

Patient Information (Please Print)

Name (Last, First) (Required):

In Care of:

Patient Address:

City: | State: | Zip:

Assigned Sex at Birth (Required): ☐ Female ☐ Male | Date of Birth (Required): | Patient ID#:

Phone Number: ☐ Cell Phone ☐ Home Phone

Race: ☐ Alaska Native or American Indian ☐ Asian ☐ Black or African American ☐ Multiracial ☐ Native Hawaiian or other Pacific Islander ☐ Other race ☐ White ☐ Does not wish to disclose ☐ Not provided

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Gender Identity: ☐ Male ☐ Female ☐ Gender nonconforming ☐ Transgender male-to-female ☐ Transgender female-to-male ☐ Does not wish to disclose ☐ Not provided ☐ Not applicable

Sexual Orientation: ☐ Bisexual ☐ Straight ☐ Gay or Lesbian ☐ Something else ☐ Does not wish to disclose ☐ Not provided ☐ Not applicable

Billing Information (Please include a copy of the front & back of card.)

Billing Type: ☐ Patient ☐ Insurance ☐ Client | Relation (Required): ☐ Self ☐ Spouse ☐ Dependant

Insured's Name (if not patient):

Insured's SS#: | Insured's DOB:

Primary Insurance Carrier: | Medicare, Medicaid or Policy ID#:

Claims Address:

Employer/Group Name: | Group#:

Clinical Information
(Necessary for accurate test interpretation of *BRCA* Testing)

Race/ Ethnicity: ☐ African American/Black ☐ Asian ☐ Jewish (Ashkenazi) ☐ Other: ☐ Caucasian ☐ Hispanic ☐ Native American

Patient Previous Genetic Testing:

☐ No history of Genetic Testing Positive test: ☐ *BRCA1* ☐ *BRCA2* Negative test: ☐ *BRCA1* ☐ *BRCA2*

Family History:

Is there a known family history of BRCA genes mutations? (Please include a copy of the family mutation report.) ☐ No family history Yes: ☐ *BRCA1* ☐ *BRCA2*

Is there any cancer in the family history? ☐ No family history ☐ Yes: (please, specify below)

Family Cancer Site	Age at Dx	Relationship	Maternal	Paternal
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Personal Patient History:

Is there any cancer in the personal history? ☐ No history of cancer ☐ Yes: (please, specify below)

Personal Cancer Site		Age at Dx	Comments/Details	
Breast:	☐ IDC (invasive ductal carcinoma)	_____	☐ Bilateral	ER (+) ☐ (-) ☐
	☐ ILC (invasive lobular carcinoma)	_____	☐ Premenopausal	PR (+) ☐ (-) ☐
	☐ DCIS (ductal carcinoma *in situ*)	_____		HER2/neu (+) ☐ (-) ☐
	☐ LCIS (lobular carcinoma *in situ*)	_____		
Ovarian	☐			
Pancreatic	☐			
Prostate	☐		Gleason Score: 2 3 4 5 6 7 8 9 10	

Other (specify):

Bone marrow transplant recipient? ☐ Yes
Current diagnosis of hematological cancer? ☐ Yes
Currently receiving radiation therapy/chemotherapy? ☐ Yes

Clinical Information (Required for Long QT Syndrome Testing)

History of Cardiac Disease	Age at Dx	Relationship	Maternal	Paternal
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Has known familial mutation testing been previously performed? ☐ No ☐ Yes (Please include a copy of the family mutation report.)
If yes, please indicate:

Gene: _____ Mutation: _____ Name of Proband: _____ Relationship to Proband: _____

Clinical Information (check all that apply):

☐ No personal history of cardiovascular disease.
☐ Syncope - If yes, provide # episodes: _____ Age of first incident: _____
☐ Palpitations.
☐ Congenital hearing loss.
☐ Cardiac arrest - If yes, provide # episodes: _____ Age of first incident: _____
☐ History of cardiomyopathy - If yes, provide # episodes: _____ Age of first incident: _____
☐ Wolff-Parkinson-White syndrome (WPW).
☐ Prolonged QT interval - If yes, provide interval: _____ msec
☐ AV block.
☐ Ventricular arrhythmias.
☐ Atrial fibrillation.
☐ Short QT interval.
☐ Rugada syndrome.
☐ Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)
☐ Other arrhythmia types: _____
☐ Additional EKG findings: _____
☐ Cardiomyopathy:
  ☐ Hypertrophic cardiomyopathy (HCM) ☐ Restrictive cardiomyopathy (RCM) ☐ Dilated cardiomyopathy (DCM)
  ☐ Left Ventricular Non-Compaction cardiomyopathy (LVNC) ☐ Other (specify): _____
☐ Cardiovascular Device implantations - If yes:
  ☐ Pacemaker (PCM) - If yes, age at implantation: _____ ☐ Stent ☐ Other (specify):_____
☐ Hyperlipidemia.
☐ Previous angioplasty.
☐ History of deep-vein or pulmonary thrombosis.
☐ Additional/Other History including any previous genetic testing (attaching report is preferred):

Medical Necessity Guidelines:

Physicians must only order tests that they have determined are medically necessary for the diagnosis and treatment of a patient. MDL offers individual tests, as well as a limited number of customized panels. MDL provides practitioners with the flexibility to choose appropriate individual tests for each specimen to assure that the convenience of ordering panels does not impede them from ordering tests/panels that are medically necessary. All tests listed in panels may be ordered individually using this test requisition form. If you choose to order a panel, please make certain that each and every test is medically necessary. If you check off a panel as your choice, MDL understands that the physician has determined that all of the component tests are medically necessary, and will perform, report and bill for all such component tests.

Specimen Collection Platform		TAT	Stability	Test Additions¥	Specimen Collection
Whole Blood	 Yellow Top Tube (ACD Solution A)	3-5 days	48 hours	30 days to add tests	1. In accordance with the standard operating procedure of your facility, collect blood in two yellow top (ACD solution A) tubes. 2. Allow the tubes to fill properly to ensure the proper blood to anticoagulant ratio. 3. Invert gently several times to mix and prevent clot formation. Do not shake the tubes. Do not centrifuge.
Saliva		5 - 10 days	48 hours	30 days to add tests	• **Vigorously rinse mouth with clean water 5 minutes prior to specimen collection (30 minutes prior is ideal).** • **After rinsing, do not brush teeth, use mouthwash, eat, drink, chew gum or smoke prior to sample collection.** 1. Begin collecting your sample by allowing saliva to pool in your mouth. Then spit into the wide funnel of the tube allowing saliva to collect in the upper chamber of the tube. Fill the tube until the amount of saliva (not bubbles) reaches the fill line as shown. 2. Once filled, unscrew the funnel allowing the saliva to flow into the lower chamber of the tube containing the stabilizing solution. Discard the funnel. 3. Use the blue cap to close the tube tightly. Shake the capped tube for 5 seconds.

¥ Pending QC review for sufficient specimen volume