

All testing must be ordered by
a qualified Healthcare Provider

PREVENTIONGENETICS USE ONLY

THIS FORM MUST ACCOMPANY ALL SPECIMENS

CANCER TEST REQUISITION FORM

PERSON COMPLETING FORM	CONTACT (PHONE OR EMAIL)	DATE OF REQUEST ____/____/____ MONTH DAY YEAR
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PATIENT INFORMATION

LAST (FAMILY) NAME	FIRST NAME	MI	DATE OF BIRTH ____/____/____ MONTH DAY YEAR
PATIENT ID	SPECIMEN COLLECTION DATE MONTH ____ / DAY ____ / YEAR ____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
SPECIMEN SOURCE <input type="checkbox"/> Whole Blood <input type="checkbox"/> Extracted DNA, Source _____ <input type="checkbox"/> Saliva <input type="checkbox"/> Direct Amniotic Fluid <input type="checkbox"/> Cultured Cells, Source _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Direct CVS <input type="checkbox"/> Tissue, Source _____		REASON FOR TEST <input type="checkbox"/> Diagnosis / Affected <input type="checkbox"/> Presymptomatic / At Risk <input type="checkbox"/> Carrier Testing	
HAS PATIENT BEEN TESTED PREVIOUSLY AT PreventionGenetics? <input type="checkbox"/> NO <input type="checkbox"/> YES, PG ID# _____		BLOOD TRANSFUSION <input type="checkbox"/> NO <input type="checkbox"/> Within Last 30 Days, Date and Type ____/____/____ MONTH DAY YEAR	BONE MARROW TRANSPLANT <input type="checkbox"/> NO <input type="checkbox"/> YES ____/____/____ MONTH DAY YEAR
HAS PATIENT'S RELATIVE BEEN TESTED PREVIOUSLY AT PreventionGenetics? <input type="checkbox"/> NO <input type="checkbox"/> YES Name and DOB or PG ID# _____		ONGOING PREGNANCY <input type="checkbox"/> NO <input type="checkbox"/> YES <i>Prenatal Healthcare Statement required for fetal testing of ongoing pregnancies.</i>	

TEST SELECTION

Select tests to be performed. Test Codes, Test Names and Turnaround Times (TAT) are available at www.PreventionGenetics.com. Include any special test instructions in the comments section.

TEST CODE	PANEL	GENES	SPECIAL INSTRUCTIONS
BREAST CANCER			<input type="checkbox"/> HOLD TESTING Pending MOH approval, insurance pre-authorization, etc. <input type="checkbox"/> SPECIMEN COLLECTED IN NEW YORK STATE Include New York State Non-Permitted Laboratory Test Request approval letter if test is not NY state approved and Genetic Testing Healthcare Provider Statement. For a list of tests that are NY state approved see website.
<input type="checkbox"/> 5431	Breast Cancer - High Risk	BRCA1, BRCA2, CDH1, PALB2, PTEN, TP53	
<input type="checkbox"/> 5433	Breast Cancer - High / Moderate Risk	ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, STK11, TP53	
<input type="checkbox"/> 5435	Breast Cancer - Comprehensive Risk	ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, MUTYH, NBN, NF1, PALB2, PTEN, RAD51C, RAD51D, STK11, TP53	<input type="checkbox"/> IF OTHER TESTS ARE DESIRED, USE STANDARD TEST REQUISITION FORM. COMMENTS
HEREDITARY BREAST AND OVARIAN CANCER			
<input type="checkbox"/> 5451	HBOC - BRCA1/2	BRCA1, BRCA2	
<input type="checkbox"/> 5453	HBOC -High Risk and Lynch	ATM, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53	
<input type="checkbox"/> 5455	HBOC - Expanded and Lynch	ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, NBN, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53	
CANCER SPECIFIC			
<input type="checkbox"/> 5457	Endometrial	BRCA1, BRCA2, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, POLD1, PTEN, TP53	
<input type="checkbox"/> 5459	Prostate	ATM, BRCA1 and BRCA2, BRIP1, CHEK2, EPCAM, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, RAD51C, RAD51D, TP53	
<input type="checkbox"/> 5461	Pancreatic	APC, ATM, BRCA1 and BRCA2, CDK4, CDKN2A, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53, VHL	
<input type="checkbox"/> 5473	Melanoma	BAP1, BRCA2, CDK4, CDKN2A, MITF, PTEN, RB1, TP53	
<input type="checkbox"/> 5463	Lynch Syndrome	EPCAM, MLH1, MSH2, MSH6, PMS2	
<input type="checkbox"/> 5465	Polyposis	APC, MUTYH, POLD1, POLE	
<input type="checkbox"/> 5467	Colorectal	APC, ATM, BMPR1A, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53	
<input type="checkbox"/> 5469	Ovarian	ATM, BARD1, BRCA1 and BRCA2, BRIP1, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, NBN, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53	
PAN			
<input type="checkbox"/> 5471	Cancer	APC, ATM, BARD1, BMPR1A, BRCA1 and BRCA2, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, EPCAM, MEN1, MLH1, MSH2, MSH6, MUTYH, NBN, NF1, PALB2, PMS2, POLD1, POLE, PTEN, RAD51C, RAD51D, RET, SMAD4, STK11, TP53, VHL	

PREVENTIONGENETICS USE ONLY

CANCER HISTORY

PATIENT INFORMATION

PERSONAL HISTORY OF CANCER / POLYPS

NO YES, How many _____

Type _____

PRIMARY CANCER TYPE

- Breast Endometrial / Uterine Melanoma
 Ovarian Pancreatic Hematological
 Colorectal Prostate _____

HAS IHC / TUMOR TESTING BEEN PERFORMED?

NO YES, describe result

PRIMARY DIAGNOSIS IF APPLICABLE

AGE OF DIAGNOSIS	CLINICAL DIAGNOSIS	TYPE

PATHOLOGY DETAILS

SECOND PRIMARY DIAGNOSIS

AGE OF DIAGNOSIS	CLINICAL DIAGNOSIS	TYPE

PATHOLOGY DETAILS

ADDITIONAL INFORMATION

FAMILY HISTORY OF CANCER OR INCLUDE PEDIGREE

CONSANGUINITY

NO YES

MATERNAL SIDE ANCESTRY

Ashkenazi Jewish None Unknown

PATERNAL SIDE ANCESTRY

Ashkenazi Jewish None Unknown

RELATION TO PATIENT		CANCER / POLYP TYPE	AGE OF ONSET
	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal		
	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal		
	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal		
	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal		
	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal		

PAST FAMILY GENETIC TESTING NO previous testing in family. YES, Include Germline, Somatic or Tumor testing results. Describe or attach copies of report.

PREVENTIONGENETICS USE ONLY

PROVIDER / LABORATORY CONTACT INFORMATION

*Our preferred method of report transmission is secure email (via ZixCorp).
Please provide an email address when possible. If you have additional specific reporting requests, indicate them below.*

PROVIDER INFORMATION

INSTITUTION

ADDRESS (City, State, Country and Postal Code)

REQUESTING PHYSICIAN (First, Last, Degree)

REQUESTING GENETIC COUNSELOR OR ALLIED PROVIDER (First, Last, Degree)

PHONE NUMBER

NPI#

PHONE NUMBER

NPI#

EMAIL

EMAIL

TEST REPORTING INSTRUCTIONS

Our preferred method of report transmission is email via ZixCorp

SECURE EMAIL VIA ZIXCORP Use above email address

DO NOT USE ZIXCORP. EMAIL RESULTS VIA SHAREFILE.

DO NOT EMAIL RESULTS. Send via fax (provide fax number):

(_____) _____ - _____

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(_____) _____ - _____

SENDOUT LABORATORY COMPLETE ONLY IF REPORT IS NEEDED

OTHER

INSTITUTION / CONTACT

INSTITUTION / CONTACT

ADDRESS (City, State, Country and Postal Code)

ADDRESS (City, State, Country and Postal Code)

PHONE NUMBER

NPI# (Where Applicable)

PHONE NUMBER

NPI# (Where Applicable)

EMAIL

EMAIL

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(_____) _____ - _____

As the ordering Healthcare Provider, I confirm I have obtained the patient's informed consent, either verbally or in writing, to perform this test. I further confirm the patient has been appropriately counseled and understands the risks, benefits, and limitations of this genetic testing and the implications of the results.

PREVENTIONGENETICS USE ONLY

BILLING - PLEASE SELECT INSTITUTIONAL OR SELF-PAY WITH OPTION TO SUBMIT TO INSURANCE

PATIENT TESTING WILL BE DELAYED UNTIL ALL OF THE BILLING REQUIREMENTS HAVE BEEN MET. PLEASE PRINT CLEARLY.

If the patient's specimen is collected in New York, a New York State Non-Permitted Laboratory Test Request approval letter (where applicable) and Genetic Testing Healthcare Provider Statement (see website) must be included before testing will proceed.
If PreventionGenetics performs pre-authorization, we will notify the patient of their covered amounts.

INSTITUTIONAL BILLING	
BILLING INSTITUTION	PO NUMBER
CONTACT	PHONE NUMBER
ADDRESS	CITY
BILLING ACCOUNT NUMBER <input type="checkbox"/> UPDATED INFO	STATE
EMAIL INVOICE VIA ZIXCORP (PROVIDE EMAIL ADDRESS)	ZIP
COPY OF TEST REPORT(S) FOR BILLING	
<input type="checkbox"/> EMAIL (VIA ZIXCORP)	
<input type="checkbox"/> OTHER (PLEASE SPECIFY)	

SELF-PAY			
THIS SECTION MUST BE FILLED OUT COMPLETELY			
RESPONSIBLE PARTY'S NAME (MUST BE 18 YEARS OR OLDER)	PHONE NUMBER	EMAIL	
ADDRESS	CITY	STATE	ZIP
ACCEPTANCE of financial responsibility for genetic testing PREVENTIONGENETICS CANNOT PROCEED WITH TESTING OF THE SPECIMEN WITHOUT A SIGNATURE BELOW.			
My signature indicates that I accept financial responsibility for all fees associated with this genetic testing order.			
SIGNATURE OF RESPONSIBLE PARTY		PRINTED NAME OF RESPONSIBLE PARTY	
DATE		DATE	
COMPLETE THE FOLLOWING FOR CREDIT CARD PAYMENT	CREDIT CARD NUMBER (VISA, DISCOVER, OR MASTERCARD ONLY)	EXPIRATION DATE	3-DIGIT SECURITY CODE
My signature authorizes PreventionGenetics to charge my credit card for services for which I am responsible.			
SIGNATURE		DATE	
SUBMIT CLAIM TO INSURANCE (OPTIONAL)			
POLICYHOLDER'S NAME (REQUIRED)	PLEASE INDICATE THE TYPE OF INSURANCE		
PRIMARY INSURANCE COMPANY NAME (REQUIRED)	<input type="checkbox"/> PRIVATE <input type="checkbox"/> MEDICARE <input type="checkbox"/> WI MEDICAID <i>We only accept WI Medicaid</i>		
INSURANCE COMPANY ADDRESS - CLAIMS	<input type="checkbox"/> ATTACH A COPY OF INSURANCE CARD both sides		
ICD-10 CODES (REQUIRED)	POLICY ID#	GROUP #	AUTHORIZATION #
PLEASE ATTACH THE FOLLOWING DOCUMENTATION <i>PreventionGenetics cannot proceed with testing of the specimen until all information is received.</i>			
<input type="checkbox"/> NPI # of Requesting Physician	<input type="checkbox"/> Relevant Medical Records addressing medical necessity and/or Letter of Medical Necessity	<input type="checkbox"/> SHARE RESULTS of benefits investigation with patient directly via email provided above	
<input type="checkbox"/> MEDICARE – signed ABN Form completed IN FULL		or FAX # () -	
<input type="checkbox"/> AUTHORIZATION NUMBER or letter of agreement from Insurance Company (if available). If not included, we will routinely perform pre-verification prior to initiating testing and will relay information to ordering provider.			
AUTHORIZATION to assign benefits and accept financial responsibility for my account			
PREVENTIONGENETICS CANNOT PROCEED WITH TESTING OF THE SPECIMEN WITHOUT A SIGNATURE BELOW.			
I authorize PreventionGenetics to release information received including, without limitation, medical information, which includes laboratory test results, such as genetic tests results, to my health plan/ insurance carrier and its Authorized Representatives. I further authorize insurance payments directly to PreventionGenetics for the services rendered. I understand my health plan/insurance/Medicare/Medicaid carrier may not approve and reimburse my medical genetic services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, medical necessity or otherwise. I understand I am financially responsible for non-covered services, co-insurance, co-payments, and policy deductibles except where my liability is limited by contract or State and Federal law. I agree to help PreventionGenetics resolve any insurance claim issues. My signature indicates that I accept financial responsibility for all fees associated with this genetic testing order, where applicable.			
SIGNATURE OF RESPONSIBLE PARTY		PRINTED NAME OF RESPONSIBLE PARTY	
DATE		DATE	

PREFERRED SPECIMEN REQUIREMENTS AND TURNAROUND TIMES (TAT)

PLEASE CONTACT US WITH ADDITIONAL SPECIMEN REQUIREMENT QUESTIONS.

STAT TAT (8-10 calendar days) available at a 25% surcharge for Sanger Sequencing and aCGH. Cannot be guaranteed for aCGH.

WHOLE BLOOD

Collect 3 ml - 5 ml of whole blood in EDTA (purple top tube) or ACD (yellow top tube), minimum 1 ml for small infants.

DNA

Send in screw cap tube at least 5 µg -10 µg of purified DNA at a concentration of at least 20 ng/µL for NGS and Sanger tests and at least 5 µg of purified DNA at a concentration of at least 100 ng/µL for gene-centric aCGH, MLPA, and CMA tests, minimum 2 µg for limited specimens. Indicate concentration on tube label. For requests requiring more than one test, send an additional 5 µg DNA per test ordered when possible.

SALIVA

Oragene™ or GeneFiX™ Saliva Collection kit used according to manufacturer instructions.

FETAL (CVS / AMNIOCYTES) AND OTHER CELL CULTURES

Culture and send at least two, T25 flasks of confluent cells. For sequencing or gene-centric aCGH panels, two flasks are often sufficient; however, some panels may require additional flasks (dependent on size of genes, amount of Sanger sequencing required, etc.). Multiple test requests may also require additional flasks. Please contact us for details. We strongly recommend maintaining a back-up culture. Fetal cell cultures are available at PreventionGenetics from direct amniotic fluid, chorionic villi, or products of conception (POC) via Test Code #995 (cost \$250). Collect 10 ml - 20 ml of direct amniotic fluid or 5 mg - 10 mg cleaned CVS tissue (~15-20 cleaned villi) or 2mm x 2mm x 2mm fresh tissue. CPT code 88235 for

amniotic fluid/chorionic villi or 88233 for POC specimens.

FRESH, FROZEN TISSUE

Collect 2mm x 2mm x 2mm tissue and flash freeze. Tissue to be sent frozen (preferably dry ice). Contact us for additional details.

BUCCAL SWAB

ORAcollect•Dx (OCD-100) collection kit used according to manufacturer instructions. Buccal

swabs are most appropriate for targeted, known variant testing.

DIRECT AMNIOTIC FLUID / CHORIONIC VILLI

Collect 10 ml -20 ml of direct amniotic fluid or 5 mg -10 mg cleaned CVS tissue (~15-20 cleaned villi). We strongly recommend maintaining a local back-up culture. Fetal cell cultures available (Test Code #995, \$250).

TEST METHOD		WHOLE BLOOD	DNA	SALIVA	CELL CULTURES	FRESH, FROZEN TISSUE	BUCCAL SWAB	DIRECT AMNIOTIC FLUID/CVS	OTHER	TURN AROUND TIME (TAT)
SEQUENCING	NextGen (NGS)	★	★	★	★	★	■	■ ^C	—	28 days
	PGxome® / PGxome Custom Panels	★	★ ^B	★	★ ^B	★	—	—	—	6 weeks
	Sanger	★	★	★	★	★	■	■ ^C	Semen ^D	18 days
DEL / DUP	Gene-centric aCGH	★	★	■	■	★	—	■ ^C	—	28 days
	MLPA	★	★ ^A	ONLY TEST #1941	★ ^A	—	—	—	—	20 days
	Chromosomal Microarray (CMA)	★	★	■	★	★	—	■	—	20 days

EXCEPTIONS

- A - Cell cultures and DNA extracted from CVS and amniocytes not accepted for MLPA; DNA extracted from saliva (except test #1941) also not accepted.
- B - Cell cultures and DNA extracted from CVS and amniocytes acceptable for PGxome for non-ongoing pregnancies only.
- C - Direct prenatal specimen types most appropriate for targeted prenatal familial variant testing (Test Code #990), and strongly discouraged for full gene and panel tests. Back-up culture highly recommended.
- D - Semen: Collect 1-2 vials and flash freeze. Vials to be sent frozen (preferably on dry ice). Contact us for details.

KEY

- ★ PREFERRED
- ACCEPTED
- NOT ACCEPTED

SHIPPING AND HANDLING INSTRUCTIONS

Please label all specimen containers with the patient's name, date of birth and/or ID number. At least two identifiers should be listed on specimen containers. We accept specimen deliveries Monday-Saturday for all specimen types except cell cultures, direct amniotic fluid, or direct chorionic villi. Cell culture deliveries are routinely accepted Monday-Thursday and require advance notice of arrival. If a Friday or Saturday delivery is necessary, please contact us to make arrangements. Saturday delivery should especially be avoided when possible as prenatal specimens are not processed over the weekend. Holiday schedules will be posted on our home page at least one week prior to major holidays.

BLOOD

DO NOT FREEZE. During hot weather, include a frozen ice pack in the shipping container. Place a paper towel or other thin material between the ice pack and the blood tube. In cold weather include an unfrozen ice pack in the shipping container as insulation. At room temperature, blood specimen is stable for up to 48 hours. If refrigerated, blood specimen is stable for up to one week.

DNA

DNA may be shipped at room temperature. Label the tube with the composition of the solute, DNA

concentration as well as the patient's name, date of birth, and/or ID number. We only accept genomic DNA for testing. We do not accept products of whole genome amplification reactions or other amplification reactions.

CELL CULTURES, DIRECT AF/CVS, AND POC

Send specimens overnight in an insulated, shatterproof container. Direct AF/CVS or POC specimens can be sent in saline or culture media at room temperature for culturing at PreventionGenetics (Test Code #995, \$250).

PRENATAL TESTING

Please sign Prenatal Healthcare Provider's Statement for ongoing pregnancies and contact us in advance regarding prenatal test requests. When possible, ship prenatal samples to arrive at PreventionGenetics no later than Thursday.

DNA GENOTYPING PANEL

For quality control purposes, the PreventionGenetics DNA Genotyping Panel is performed on all clinical specimens. Genotyping results are not included in test reports.

DNA BANKING

DNA Banking has a reduced price of \$98 for patients if clinical testing is also being performed at PreventionGenetics. Visit our website at www.

PGDNABank.com for information about the process and forms. For questions related to PGDNABanking, contact our DNA Banking Director at (715) 387-0484, ext. 151, or email: dnabanking@preventiongenetics.com.

CONTACT US

For additional questions or concerns, please contact our Client Service Representatives at (715) 387-0484, ext. 0, or our Genetic Counseling Team at option 2, or email: clinicaldnatesting@preventiongenetics.com.

ADDRESS

PreventionGenetics - Diagnostic Lab
3800 S. Business Park Ave.
Marshfield, Wisconsin 54449
USA

TESTING KITS

Clinical testing kits with prepaid return shipping are available for U.S. Clients. We are able to provide clinical testing kits to International clients without the return postage. To order test kits, submit requests through our electronic order form (see website) or contact our Client Service Representatives at (715) 387-0484, ext. 0.