Hereditary Cancer (Comp) Requisition

Please attach detailed medical records, insurance card front/back, and clinical information to the requisition form.

PRIMARY PATIENT

LAST NAME	FIRST NAME
DATE OF BIRTH (MM/DD/YYYY)	GENETIC SEX Male Female Unknown
MED REC#/PATIENT IDENTIFIER	ETHNICITY

ADDRESS

CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY

PHONE	EMAIL
SAMPLE DRAW DATE (MM/DD/YYYY)	SAMPLE TYPE Blood Bucal Other Extracted DNA & DNA Source: (Blood, Bucal, Tissue, Fibroblast)

I have read the Informed Consent document and I give permission to Tesis Labs to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at Tesis Labs and for publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications. More information is available at www.Tesislabs.com.

Opt out of research

Check this box if you are a New York state resident and give permission for Tesis labs to retain any remaining sample longer than 60 days after the completion of testing.

PATIENT SIGNATURE (REQUIRED FOR BILLING PURPOSES)	DATE (MM/DD/YYYY)
X	

ORDER PROVIDER

INSTITUTION/PRACTICE NAME	INSTITUTION PHONE/FAX/EMAIL
PROVIDER LAST NAME	PROVIDER FIRST NAME

NPI (USA)	MINC (CANADA)	PROVIDER TITLE (MD, DO, GC)

PROVIDER ADDRESS

CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY

PROVIDER PHONE	FAX REPORT TO
GC/PRIMARY CONTACT	GC/PRIMARY CONTACT PHONE/EMAIL/FAX

I attest that the patient has received and read the Tesis Labs Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any Tesis Labs Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

STATEMENT OF MEDICAL NECESSITY
By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

ORDERING PROVIDER SIGNATURE (REQUIRED)	DATE (MM/DD/YYYY)
X	

TEST REQUESTED

TEST NAME (see Page 3 for list of genes/panels)

+ADD/-MINUS GENES

INDICATIONS FOR TESTING
Check all that apply.

- Diagnostic
- Presymptomatic
- Family History
- Family Variant
- Other

CLINICAL/SUSPECTED DIAGNOSIS:
Please attach medical records or complete Page 2.

INSURANCE BILLING

Attach front and back of all insurance cards, ABN, medical criteria form

PLEASE ATTACH INSURANCE CARDS FOR BILLING	ICD-10 VALID CODE	REFERRAL/PRIOR AUTH	By signing above, the patient or insured authorizes Tesis Labs Genetics to release medical information concerning the test to the assigned insurance company.

PRIMARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)
SECONDARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)

INSTITUTIONAL BILLING

INSTITUTION/PRACTICE NAME
ATTENTION TO
ADDRESS

CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY

PHONE	FAX/EMAIL

SELF PAY

Use patient information above for billing Use information below for billing	By signing above, the patient or payor authorizes Tesis Labs to contact them directly, and use the provided billing instructions to bill the indicated method.
PAYOR LAST NAME	PAYOR FIRST NAME

ADDRESS

CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY

PHONE	FAX/EMAIL

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CLINICAL DETAILS (Check all that apply)

No Personal History Cancer

Cancer/Tumor Type	Onset Age	
Brain		
Breast		ER: POS (+) NEG (-) UNK (?) PR: POS (+) NEG (-) UNK (?) HER2/neu: POS (+) NEG (-) UNK (?)
2nd Primary Breast		ER: POS (+) NEG (-) UNK (?) PR: POS (+) NEG (-) UNK (?) HER2/neu: POS (+) NEG (-) UNK (?)
Colorectal		Location: ______
Hematologic*		
GI Polyps		Adenomatous Other: ______ Number of Polyp(s)#: ______

Cancer/Tumor Type	Onset Age	Pathology and Other Info
Melanoma		
Ovarian Fallopian Tube Primary Peritoneal		Serous Mucinous Endometrioid Clear cell Borderline / LMP Other: ______
Pancreatic		
Prostate		Gleason Score: ______ Metastatic: Yes No
Uterine		
Other Cancer		

Other Clinical History:

PREVIOUS OR CURRENT TREATMENT

Allogeneic bone marrow or peripheral stem cell transplant* Chemotherapy* Radiation Surgery, Specify: ______

*DNA analysis from blood samples of individuals who have undergone stem cell transplants, bone marrow transplants, or chemotherapy may not reect the germline genotype. Similarly, DNA analysis from blood samples of individuals with hematologic malignancy may not distinguish between somatic and germline variants.

CLINICAL TESTING RESULTS

Attach relevant reports

Germline testing results: ______

Somatic testing results: ______

TUMOR TESTING RESULTS

Attach relevant reports

Microsatellite instability (MSI) results: ______

Immunohistochemistry (IHC) results: ______

Other, specify: ______

FAMILY HISTORY

Attach pedigree and additional pages as needed

FAMILY MEMBER 1 NAME	RELATION TO PATIENT	GENETIC SEX Male Female Unknown	
DIAGNOSIS AND/OR SYMPTOMS		AGE OF ONSET	DOB (MM/DD/YYYY)
FAMILY MEMBER 2 NAME	RELATION TO PATIENT	GENETIC SEX Male Female Unknown	
DIAGNOSIS AND/OR SYMPTOMS		AGE OF ONSET	DOB (MM/DD/YYYY)
FAMILY MEMBER 3 NAME	RELATION TO PATIENT	GENETIC SEX Male Female Unknown	
DIAGNOSIS AND/OR SYMPTOMS		AGE OF ONSET	DOB (MM/DD/YYYY)

A CLIA Accredited Laboratory: 1408 Horizon Ave, Suite #101, Lafayette CO, 80026

P: (720) 726-2130 | F: (720) 863-2042 | info@tesislabs.com

Hereditary Cancer (Comp) Requisition

Please attach detailed medical records, insurance card front/back, and clinical information to the requisition form.

INSTRUCTIONS

1. Complete the patient and provider information section.
2. Read and sign the informed consent policy statement. The complete patient in formed consent form for genetic testing can be found on tesislabs.com. Signature from the provider on Page 1 of the TRF is required for all testing . Signature from the patient is only required for billing purposes.
3. Write in the test name on Page 1 or select the gene(s)/panel(s) below.
4. Indicate any relevant test options on Page 1.
5. Please visit tesislabs.com for specimen requirements.

Extracted DNA must extracted from a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by CAP an d/or CMS.

REQUIRED FOR INSURANCE CHECKLIST

- Detailed medical record (pedigree if available)
- ICD-10 codes(s)
- Physician, patient, and insured signatures
- Copy of insurance card(s) - front/back
- Insurer specific forms (i.e. ABN)
- Insurance authorization, if available
- For medicare, medicare criteria form is required

For the most updated information and limitations on our products and services, please visit www.tesislabs.com

SELEC PANEL – *Select only one test*

Comprehensive Cancer
Select all available genes.

Breast Cancer STAT (7-10 day TAT)
ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, STK11, TP53

Breast Comprehensive
ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, MLH1, MRE11, MSH2, NBN, NF1, PALB2, PTEN, RAD50, RAD51C, RAD51D, STK11, TP53, XRCC2

Breast and Ovarian Comprehensive
ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, MLH1, MRE11, MSH2, NBN, NF1, PALB2, PTEN, RAD50, RAD51C, RAD51D, STK11, TP53, XRCC2

Colorectal Comprehensive
APC, AXIN2, BMPR1A, CDH1, CHEK2, EPCAM, FAN1, GALNT12, GREM1, MLH1, MLH3, MSH2, MSH6, MUTYH, NTHL1, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53

Endometrial Comprehensive
BRCA1, BRCA2, EPCAM, MLH1, MSH2, MSH6, PMS2, POLD1, PTEN, TP53

Gastric Comprehensive
APC, BMPR1A, CDH1, CTNNA1, EPCAM, KIT, MLH1, MSH2, MSH6, NF1, PDGFRA, PMS2, SMAD4, STK11, TP53

Hematologic Malignancy Comprehensive
ATM, BLM, CEBPA, EPCAM, GATA2, HRAS,MLH1, MSH2, MSH6, NBN, NF1, PMS2, RUNX1, TERC, TERT, TP53

Melanoma Comprehensive
BAP1, BRCA2, CDK4, CDKN2A, CHEK2, MC1R, MITF, POT1, PTEN, RB1, SLC45A2, TP53, TYR

Nervous System / Brain Comprehensive
ALK, APC, ATM, DICER1, EPCAM, HRAS, LZTR1, MEN1, MLH1, MSH2, MSH6, NF1, NF2, PHOX2B, PMS2, PRKAR1A, PTCH1, PTEN, POT1, SMARCA4, SMARCB1, SMARCE1, SUFU, TP53, TSC1, TSC2, VHL

Ovarian Comprehensive
BARD1, BRCA1, BRCA2, BRIP1, CDH1, EPCAM, MLH1, MRE11, MSH2, MSH6, NBN, PALB2, PMS2, RAD51C, RAD51D, SMARCA4, STK11, TP53

Pancreatic Comprehensive
APC, ATM, BMPR1A, BRCA1, BRCA2, CDK4, CDKN2A, EPCAM, FANCC, MEN1, MLH1, MSH2, MSH6, NF1, PALB2, PMS2, SMAD4, STK11, TP53, TSC1, TSC2, VHL

Paraganglioma-Pheochromocytoma Comprehensive
FH, MAX, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL

Prostate Comprehensive
ATM, BRCA1, BRCA2, CHEK2, EPCAM, HOXB13, MLH1, MSH2, MSH6, NBN, PMS2, TP53

Renal / Urinary Comprehensive
BAP1, CDC73, CDKN1C, DICER1, DIS3L2, EPCAM, FH, FLCN, GPC3, MET, MITF, MLH1, MSH2, MSH6, PMS2, PTEN, SDHA, SDHB, SDHC, SDHD, SMARCA4, SMARCB1, TP53, TSC1, TSC2, VHL, WT1

Sarcoma Comprehensive
APC, BLM, CDKN1C, DICER1, EPCAM, FH, HRAS, KIT, MLH1, MSH2, MSH6, NBN, NF1, PDGFRA, PMS2, PRKAR1A, PTCH1, RB1, RECQL4, SDHA, SDHB, SDHC, SDHD, SUFU, TP53, WRN

Thyroid Comprehensive
APC, CHEK2, DICER1, PRKAR1A, PTEN, RET, TP53

Custom
Select genes below to create a custom panel.

If I am covered by insurance, I authorize TESIS LABS and their contracted billing company to give my insurance carrier the information on this form and provided by my healthcare provider that is necessary for reimbursement. I understand that I am responsible for deductible and coinsurance amounts as indicated by my insurance carrier. I agree to assist in resolving insurance claim issue ans if I do not assist, I may be responsible for the sill cost of the test. I understand that I am responsible for sending TESIS LABS any and all of the money that I receive directly from my insurance carrier in payment for this test.

If the test is not authorized by or is not covered by my insurance, than I will be contacted with the option to either cancel the ordered test or elect to pay out-of-pocket according to the proposed payment plan provided to me when I am contacted. If I elect to pay out-of-pocket, I will be responsible for all payment obligations arising from the ordered testing and guarantee payment for these services. I understand that if payments or arrangements are not made after 3 statements my information may be sent to collections.

Tesis Labs is committed to support you with your share of costs. If required, you will be contacted by our team to setup a payment plan for your portion of the costs using the following forms of payment: Check, Visa, Master Card. You may also contact our billing team at 720-726-2130

PATIENT SIGNATURE (REQUIRED FOR BILLING PURPOSES)	DATE (MM/DD/YYYY)
X	

RE-REQUISITION INSTRUCTIONS

Re-requisition for additional genetic testing is at no additional charge within 90 days of the original report release date. Any re-requisitioned test must be ordered from the same cancer category of tests. If you would like the results from the rst test included in the next report, please also select the original test panels and genes.

1. Indicate which panels and genes you would like tested on this page.
2. Fill in the identiers to the right based on the previous report.
3. If provider information and patient clinical information has not changed, only this third page is required for re-requisition.
4. It the provider information has changed, the rst page is required.
5. If the patient's clinical information has changed, the second page is required.

LAST NAME	FRIST NAME
DATE OF BIRTH (MM/DD/YYYY)	MED REC#/PATIENT IDENTIFIER