

**HEREDITARY CANCER REQUISITION**

**PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)**

\_\_\_\_\_  
Patient Last Name                      Patient First Name                      MI                      Date of Birth (MM/DD/YY)

\_\_\_\_\_  
Address                      Accession #                      Hospital/ Medical Record #

\_\_\_\_\_  
City                      State                      Zip                      Phone                      Biological Sex:  M  F  Unknown

Gender identity (if different from above): \_\_\_\_\_

**REPORTING RECIPIENTS**

\_\_\_\_\_  
Ordering Physician                      Institution Name

\_\_\_\_\_  
Email (Required for International Clients)                      Phone                      Fax

**ADDITIONAL RECIPIENTS**

\_\_\_\_\_  
Name                      Name

\_\_\_\_\_  
Email                      Fax                      Email                      Fax

**PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)**

**SELF PAYMENT**

Bill Patient For Laboratory Testing

**INSTITUTIONAL BILLING**

\_\_\_\_\_  
Institution Name                      Institution Code                      Institution Contact Name                      Institution Phone                      Institution Contact Email

**INSURANCE**

Do Not Perform Test Until Patient is Aware of Out-Of-Pocket Costs (excludes prenatal testing)

REQUIRED ITEMS 1. Copy of the Front/Back of Insurance Card(s) 2. ICD10 Diagnosis Code(s) 3. Name of Ordering Physician 4. Insured Signature of Authorization

\_\_\_\_\_  
Name of Insured                      Insured Date of Birth (MM/DD/YY)                      Address of Insured

\_\_\_\_\_  
Patient's Relationship to Insured                      Phone of Insured                      City                      State                      Zip

\_\_\_\_\_  
Primary Insurance Co. Name                      Primary Insurance Co. Phone                      Primary Member Policy #                      Primary Member Group #

\_\_\_\_\_  
Secondary Insurance Co. Name                      Secondary Insurance Co. Phone                      Secondary Member Policy #                      Secondary Member Group #

By signing below, I hereby authorize Baylor Genetics to provide my designated insurance carrier any information necessary, including test results, for processing my insurance claim. I also authorize benefits to be payable exclusively to Baylor Genetics. I understand that my insurance carrier may not approve or reimburse my medical genetic services in full or any portion thereof, due to a variety of reasons, including, but not limited to: the contract status of my insurance provider with Baylor Genetics, usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates. I understand that I am responsible for any amounts not paid by my insurance carrier for reasons including, but not limited to, non-covered and non-authorized services. I understand that I am responsible for sending Baylor Genetics, any and all payments that I receive directly from my insurance company in payment for this test. Please note that Medicare does not cover routine screening tests.

\_\_\_\_\_  
Patient's Name                      Patient's Signature                      Date

**STATEMENT OF MEDICAL NECESSITY (REQUIRED)**

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

\_\_\_\_\_  
Physician's Printed Name                      Physician's Signature                      Date

**HEREDITARY CANCER REQUISITION**

Patient Last Name \_\_\_\_\_ Patient First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth (MM/DD/YY) \_\_\_\_\_ Biological Sex \_\_\_\_\_

**ETHNICITY**

- African American
- Ashkenazi Jewish
- East Asian (China, Japan, Korea)
- Finnish
- French Canadian
- Hispanic American
- Mennonite
- Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey)
- Native American
- Northern European Caucasian (Scandinavian, UK, Germany)
- Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia)
- South Asian (India, Pakistan)
- Southeast Asian (Vietnam, Cambodia, Thailand)
- Southern European Caucasian (Spain, Italy, Greece)
- Other (Specify) \_\_\_\_\_

**INDICATION FOR TESTING (REQUIRED)**

ICD10 Diagnosis Code(s) \_\_\_\_\_

- Personal History
- Type of Cancer \_\_\_\_\_
- Cancer Location \_\_\_\_\_
- Age at Diagnosis \_\_\_\_\_
- Family History (include relationship to family member, cancer type, age at diagnosis):

**SAMPLE**

**SAMPLE TYPE**

- Blood in EDTA-tube (purple-top)
- DNA (Specify): \_\_\_\_\_
- Saliva
- Other (Specify) \_\_\_\_\_

Note: Blood should not be sent from patients who have had a bone marrow transplant or recent blood transfusion

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Collection (MM/DD/YY)

**TESTING OPTIONS**

- Targeted Sequencing for Known Familial Mutation  
(If selected, complete section to right)
- Full Gene Sequencing
- Deletion/ Duplication Analysis

**FOR TARGETED TESTING SELECTION ONLY**

Proband Last Name \_\_\_\_\_ Proband First Name \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth (MM/DD/YY) Relationship of Proband to Patient \_\_\_\_\_

Proband testing location (Select one)

- Baylor Genetics \_\_\_\_\_  
Lab # \_\_\_\_\_ Family # \_\_\_\_\_
- Another laboratory

1. Attach a copy of the Proband test results
2. A positive control sample of the Proband is requested. Please provide, if available.

**HEREDITARY CANCER TESTS**

**HEREDITARY CANCER PANELS**

TEST CODE	TEST NAME	SAMPLE TYPE *	TEST CODE	TEST NAME	SAMPLE TYPE *
<input type="checkbox"/> 20004	Comprehensive Hereditary Cancer (61 genes)	BE	<input type="checkbox"/> 23204	Colorectal Cancer, High Risk (12 genes)	BE
<input type="checkbox"/> 24000	Hereditary Cancer (27 genes)	BE	<input type="checkbox"/> 22704	Leukemia/Lymphoma (13 genes)	BE
<input type="checkbox"/> 22304	Brain/CNS/PNS Cancer (17 genes)	BE	<input type="checkbox"/> 22904	Melanoma ( <i>BRCA2, CDKN2A, CDK4, TP53</i> )	BE
<input type="checkbox"/> 22404	Breast/Ovarian/Endometrial Cancer (23 genes)	BE	<input type="checkbox"/> 23304	Pancreatic Cancer (16 genes)	BE
<input type="checkbox"/> 23000	Breast Cancer, High Risk (7 genes)	BE, DNA, SA	<input type="checkbox"/> 23104	Paraganglioma/ Pheochromocytoma (9 genes)	BE
<input type="checkbox"/> 22604	Endocrine Cancer (15 genes)	BE	<input type="checkbox"/> 23404	Prostate Cancer ( <i>BRCA1, BRCA2, CHEK2, NBN, and TP53</i> )	BE
<input type="checkbox"/> 22804	Colorectal/Gastrointestinal (GI) Cancer (22 genes)	BE	<input type="checkbox"/> 22504	Renal Cancer (12 genes)	BE

\* Refer to Sample Specifications Table on Page 3

**HEREDITARY CANCER REQUISITION**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Last Name Patient First Name MI Date of Birth (MM/DD/YY) Biological Sex

**HEREDITARY CANCER TESTS**

**SINGLE GENE ANALYSIS**

Most individual gene tests have sequencing and deletion/duplication studies along with the comprehensive analysis, which includes both sequencing and deletion/duplication. Only the comprehensive test codes are listed below. If requesting individual sequencing and/or deletion/duplications codes, please obtain the test code from our website and write in the below space(s).

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Test Code Gene Test Code Gene Test Code Gene  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Test Name Test Name Test Name

TEST CODE	TEST NAME	DISORDER	SAMPLE TYPE *
<input type="checkbox"/> 6720	APC Comprehensive (Seq & Del/Dup Analysis)	APC-Associated Polyposis Conditions	BE
<input type="checkbox"/> 6520	RUNX1 Sequence Analysis	Familial Thrombocytopenia with Propensity to AML	BE
<input type="checkbox"/> 22350	BRCA1 & BRCA2 Comprehensive Sequence & CNV Analysis by NGS	Hereditary Breast/Ovarian Cancer	BE, DNA, SA
<input type="checkbox"/> 22820	ENG Sequence Analysis by NGS	Hereditary Hemorrhagic Telangiectasia Type 1	BE, DNA
<input type="checkbox"/> 3740	FH Sequence Analysis	Hereditary Leiomyomatosis and Renal Cell Cancer (FH-Related Disorders)	BE, SA
<input type="checkbox"/> 6705	MLH1 Comprehensive (Seq & Del/Dup Analysis)	Hereditary Non-Polyposis Colon Cancer (HNPCC) - Blood Analysis	BE
<input type="checkbox"/> 6710 & 6888	MSH2 Comprehensive (Seq & Del/Dup Analysis) AND EPCAM Deletion/Duplication Analysis (by MLPA)	Hereditary Non-Polyposis Colon Cancer (HNPCC) - Blood Analysis	BE
<input type="checkbox"/> 6715	MSH6 Comprehensive (Seq & Del/Dup Analysis)	Hereditary Non-Polyposis Colon Cancer (HNPCC) - Blood Analysis	BE
<input type="checkbox"/> 6890	PMS2 Comprehensive (Seq & Del/Dup Analysis)	Hereditary Non-Polyposis Colon Cancer (HNPCC) - Blood Analysis	BE
<input type="checkbox"/> 6888	EPCAM Deletion/Duplication Analysis (by MLPA)	Hereditary Non-Polyposis Colon Cancer (HNPCC) - Blood Analysis	BE
<input type="checkbox"/> 6821	TP53 Comprehensive (Seq & Del/Dup Analysis)	Li-Fraumeni Syndrome (LFS)	BE
<input type="checkbox"/> 3665	MENT Sequence Analysis	Multiple Endocrine Neoplasia, Type 1	BE, SA
<input type="checkbox"/> 3660	RET Sequence Analysis	Multiple Endocrine Neoplasia, Type 2 (RET-Related Disorders)	BE, SA
<input type="checkbox"/> 6120	MUTYH (MYH) Sequence Analysis	MUTYH (MYH) - Associated Polyposis	BE
<input type="checkbox"/> 6104	MUTYH (MYH) Mutation PANEL (2 Mutations)	MUTYH (MYH) - Associated Polyposis	BE
<input type="checkbox"/> 3600	SDHB, SDHC, & SDHD Sequence PANEL	PHEO and PGL Syndromes	BE, SA
<input type="checkbox"/> 6790	PTEN Comprehensive (Seq & Del/Dup Analysis)	PTEN-Related Disorders	BE
<input type="checkbox"/> 6121	RECQL4 Sequence Analysis	Rothmund-Thomson Syndrome (RECQL4 -Related Disorders)	BE
<input type="checkbox"/> 6770	VHL Comprehensive (Seq & Del/Dup Analysis)	Von Hippel-Lindau Syndrome	BE

**SAMPLE SPECIFICATIONS TABLE**

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT		SHIPPING INSTRUCTIONS	SPECIAL NOTES
		(2 yrs - Adult)	(Newborn - 2 yrs)		
BE	Blood in EDTA tube (purple-top)	10 cc	2 -3 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	
DNA	DNA, Extracted	10 ug	10 ug	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Attach clinical notes and pathology reports, if available.
SA	Saliva	See Special Notes	See Special Notes	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Collected with Oragene DNA Self-Collection Kit.