BAYLOR GENETICS

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
GRAND BLVD. RECEIVING DOCK
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

HEREDITARY CANCER REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY)

Address | City | State | Zip | Phone

Accession # | Hospital / Medical Record #

Patient discharged from the hospital/facility: ◯ Yes ◯ No

Biological Sex: ◯ Female ◯ Male ◯ Unknown

Gender identity (if different from above):

REPORTING RECIPIENTS

Ordering Physician | Institution Name

Email (Required for International Clients) | Phone | Fax

ADDITIONAL RECIPIENTS

Name | Email | Fax

Name | Email | Fax

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

◯ **SELF PAYMENT**

☐ Pay With Sample ☐ Bill To Patient

◯ **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 / YYYY)

Patient's Relationship to Insured | Phone of Insured

Address of Insured

City | State | Zip

Primary Insurance Co. Name | Primary Insurance Co. Phone

Primary Member Policy # | Primary Member Group #

Name of Insured | Insured Date of Birth (MM / DD / YYYY)

Patient's Relationship to Insured | Phone of Insured

Address of Insured

City | State | Zip

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 insurance carrier any information necessary, including test results, for processing my insurance claim. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates, as well as 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 Printed Name | Patient's Signature | Date (MM / DD / YYYY)

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 (MM / DD / YYYY)

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Patient Last Name _____ Patient First Name _____ MI _____ Date of Birth (MM / DD / YYYY) ____ / ____ / ____ 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): _____

SAMPLE

SAMPLE TYPE

- ◯ Blood in EDTA (Purple-top)
- ◯ DNA (Specify): _____
- ◯ Buccal Swab
- ◯ Saliva
- ◯ Other (Specify): _____

Date of Collection: ____ / ____ / ____ (MM / DD / YYYY)

NOTE: Extracted DNA/RNA will only be accepted if the isolation of nucleic acids for clinical testing occurs in a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by the CAP and/or the CMS.

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

TESTING OPTIONS

☐ Targeted Sequencing for Known Familial Mutation (If selected, complete section below)

Proband Last Name _____ Proband First Name _____

Relationship to Proband _____ Date of Birth (MM/DD/YYYY) ____ / ____ / ____

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.

☐ Full Gene Sequencing

☐ Deletion/ Duplication Analysis

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)

HEREDITARY CANCER TESTS

HEREDITARY CANCER PANELS

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

* Refer to Sample Specifications Table (Page 8)

Test list continued on next page

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Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY) | 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 *
☐ 6720	*APC* Comprehensive (Seq & Del/Dup Analysis)	APC-Associated Polyposis Conditions	BE
☐ 6520	*RUNX1* Sequence Analysis	Familial Thrombocytopenia with Propensity to AML	BE
☐ 22350	*BRCA1 & BRCA2* Comprehensive Sequence & CNV Analysis by NGS	Hereditary Breast/Ovarian Cancer	BE, DNA, SA
☐ 22820	*ENG* Sequence Analysis by NGS	Hereditary Hemorrhagic Telangiectasia Type 1	BE, DNA
☐ 3740	*FH* Sequence Analysis	Hereditary Leiomyomatosis and Renal Cell Cancer (FH-Related Disorders)	BE, SA
☐ 6705	*MLH1* Comprehensive (Seq & Del/Dup Analysis)	Hereditary Non-Polyposis Colon Cancer (HNPCC) - Blood Analysis	BE
☐ 6710 & 6888	*MSH2* Comprehensive (Seq & Del/Dup Analysis)AND *EPCAM* Deletion/ Duplication Analysis (by MLPA)	Hereditary Non-Polyposis Colon Cancer (HNPCC) - Blood Analysis	BE
☐ 6715	*MSH6* Comprehensive (Seq & Del/Dup Analysis)	Hereditary Non-Polyposis Colon Cancer (HNPCC) - Blood Analysis	BE
☐ 6890	*PMS2* Comprehensive (Seq & Del/Dup Analysis)	Hereditary Non-Polyposis Colon Cancer (HNPCC) - Blood Analysis	BE
☐ 6888	*EPCAM* Deletion/Duplication Analysis (by MLPA)	Hereditary Non-Polyposis Colon Cancer (HNPCC) - Blood Analysis	BE
☐ 6821	*TP53* Comprehensive (Seq & Del/Dup Analysis)	Li-Fraumeni Syndrome (LFS)	BE
☐ 3665	*MEN1* Sequence Analysis	Multiple Endocrine Neoplasia, Type 1	BE, SA
☐ 3660	*RET* Sequence Analysis	Multiple Endocrine Neoplasia, Type 2 (RET-Related Disorders)	BE, SA
☐ 6120	*MUTYH (MYH)* Sequence Analysis	MUTYH (MYH) - Associated Polyposis	BE
☐ 6104	*MUTYH (MYH)* Mutation PANEL (2 Mutations)	MUTYH (MYH) - Associated Polyposis	BE
☐ 3600	*SDHB, SDHC, & SDHD* Sequence PANEL	PHEO and PGL Syndromes	BE, SA
☐ 22335	*PHOX2B* Sequence Analysis	PHOX2B-Related Disorders	BE, DNA
☐ 6790	*PTEN* Comprehensive (Seq & Del/Dup Analysis)	PTEN-Related Disorders	BE
☐ 6121	*RECQL4* Sequence Analysis	Rothmund-Thomson Syndrome (RECQL4 -Related Disorders)	BE
☐ 6770	*VHL* Comprehensive (Seq & Del/Dup Analysis)	Von Hippel-Lindau Syndrome	BE

SAMPLE SPECIFICATIONS TABLE

ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT (2 YRS - ADULT)	RECOMMENDED AMOUNT (NEWBORN - 2YRS)	SHIPPING INSTRUCTIONS	SPECIAL NOTES
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.	
BUC	Buccal Swab	See Special Notes	See Special Notes	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze. Sample must arrive within 72 hours.	Collect with ORAcollect•Dx (OCD-100) self-collection kit (provided by Baylor Genetics with instructions). It is highly recommend that the sample be collected by a healthcare professional.
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.