PATIENT NAME	
DATE OF BIRTH	TODAY'S DATE

Hereditary Cancer Questionnaire

(to be completed by patients)

Instructions: This is a screening tool to help your healthcare provider determine if you would benefit from hereditary cancer genetic testing. Your healthcare provider will review this form looking for any risk factors of a hereditary cancer syndrome such as **personal history of cancer**, similar types of cancer running in the family, cancers diagnosed at young ages, or multiple cancer diagnoses in the same person. This "Personal & Family History" tool will also be used by an Independent Genetic Counselor to assist you and your health care provider to determine your hereditary cancer risk and if genetic testing is right for you and your family.

HAVE YOU HAD CANCER? DOES CANCER RUN IN YOUR FAMILY? Check those that apply.

Please fill this form out to the best of your ability. Please record your own personal history along with family members related to you by blood, such as your parents, grandparents, children, brothers, sisters, aunts, uncles, and cousins. If you share only one parent with a brother or sister, please indicate that. Be sure to note the gender of a relative if not obvious. First names are helpful, if there are multiple relatives and/or multiple cancers.

TYPE OF CANCER TUMORS	YOURSELF/ BROTHERS/SISTERS/ CHILDREN	AGE AT DIAGNOSIS (Estimates are ok)	EXTENDED FAMILY (MOTHER'S SIDE) Aunts/ Uncles/ Cousins/ Grandparents / Other	AGE AT DIAGNOSIS (Estimates are ok)	EXTENDED FAMILY (FATHER'S SIDE) Aunts/ Uncles/ Cousins/ Grandparents / Other	AGE AT DIAGNOSIS (Estimates are ok)
☐ EXAMPLE: Colorectal Cancer	Me	42	Aunt (Jane) Cousin (female, Pam)	58 37	Aunt (Annie) Uncle	46 55
☐ BREAST CANCER (in women or men)						
☐ OVARIAN CANCER (Peritoneal/ Fallopian tube)						
☐ UTERINE (ENDOMETRIAL) CANCER						
☐ COLORECTAL CANCER						
☐ PANCREATIC CANCER						
☐ PROSTATE CANCER						
☐ KIDNEY (RENAL) CANCER						
☐ MELANOMA						
☐ BRAIN TUMOR Type:_____						
☐ GASTRIC						
☐ ENODOMETRIAL						

PATIENT NAME	
DATE OF BIRTH	TODAY'S DATE

Hereditary Cancer Questionnaire
(continued)

TYPE OF CANCER TUMORS	YOURSELF/ BROTHERS/SISTERS/ CHILDREN	AGE AT DIAGNOSIS (Estimates are ok)	EXTENDED FAMILY (MOTHER'S SIDE) Aunts/ Uncles/ Cousins/ Grandparents / Other	AGE AT DIAGNOSIS (Estimates are ok)	EXTENDED FAMILY (FATHER'S SIDE) Aunts/ Uncles/ Cousins/ Grandparents / Other	AGE AT DIAGNOSIS (Estimates are ok)
☐ EXAMPLE: Colorectal Cancer	Me	42	Aunt (Jane) Cousin (female, Pam)	58 37	Aunt (Annie) Uncle	46 55
☐ LYNCH SYNDROME						
☐ LUNG CANCER						
☐ THYROID CANCER						
☐ SARCOMA						
☐ LEUKEMIA						
☐ CARCINOMA						
☐ OTHER CANCER Type:_____						
☐ OTHER CANCER Type: _____						
☐ MORE THAN 10 COLORECTAL POLYPS (indicate how many)						

☐ No personal or family history of cancer

☐ My family's heritage is Ashkenazi Jewish (an ethnic background that may have a higher likelihood of hereditary cancer)

☐ I, or someone in my family, have had genetic testing for a hereditary cancer syndrome.
(Please describe and provide a copy of test result if possible)

_____

_____

Personal History of:	**Date of Procedure**	**Details:** (reason for procedure)
☐ Bone Marrow Transplant	_____	_____
☐ Stem Cell Transplant	_____	_____
☐ Blood Transfusion	_____	_____
☐ (Other) Transfusion	_____	_____

Absolute Genomics

Patient Consent for Genetic Counseling & Multi-Gene Cancer Panels
Genetic Testing for Hereditary Cancer

Testing for genetic conditions is complex. You should discuss testing with your physician or a professional genetic counselor prior to giving consent, to fully understand the risks and benefits of having this testing completed. Pre- and post-test genetic counseling provided by a qualified specialist, such as a genetic counselor or medical geneticist is required for all individuals undergoing genetic testing.

I hereby consent to participate in Pre & Post Genetic Counseling for Hereditary Cancer Genetic Testing and my signature at the end of this form will serve as evidence that I consent to be evaluated and for the test to be performed. I have read and agree to the statements below.

* **I understand the following information regarding the test purpose and methodology:**
The purpose of this molecular genetic test is to determine if a patient carries any mutation(s) causing increased risk to develop cancer.
This test will include analysis of all genes included in a cancer panel or individual genes indicated by a health care provider along with a third party licensed professional genetic counselor. I also understand and authorize to be contacted by a licensed healthcare provider with the testing lab to gather missing personal and family medical history to fully document information to assist in determining potential increased risk factors. I also understand that the exact genes to be tested will not be determined until after the signing of this consent and will be determined when the genetic counselor completes the 3 generation in-depth review of my individual personal and family history of cancer to determine my risk. I also understand that my test will not be completed if I do not participate in the required genetic counseling or if it is determined that the test is not medically necessary according to NCCN guidelines and my insurance carrier's medical policy. This testing requires pre-authorization/ pre-determination approval of my insurance carrier. If this is not received, I will be given a cash price option for the test prior to the test being run by Absolute Genomics / Global Reach Labs and it will only be performed with my approval.
The blood, body fluid, or tissue specimen submitted is required for isolation and purification of DNA for molecular genetic testing. I understand that this specimen will be used for the purpose of attempting to determine if I am a carrier of the disease gene, or am affected with, or at increased risk to someday be affected with this genetic disease.

* **I understand the following information regarding Absolute Genomics / Global Reach Labs results disclosure policy:**
Due to the complexity of DNA-based testing and the important implications of the test results, these results will be reported through my designated physician or genetic counselor and I should contact my provider to obtain, discuss the results of the test, and schedule counseling regarding potential specialist interventions for clinically significant test results. Additionally, the test results could be released to all who, by law, may have access to such data. I am aware that Absolute Genomics / Global Reach Labs will store my samples and data indefinitely. Information may be shared with other researchers in the future but those researchers will not be able to identify me. My data and samples may be used in any type of research. My samples, data and genetic data generated from the samples may be shared with others, federal repositories and will be shared without identifiers. Any information that cannot be unidentifiable will not be shared without additional consent.

* **I understand the following information regarding test results:**
Genes included on this test may be associated with several different types of cancer and are also associated with varying levels of cancer risk. My health care provider's recommendations for my medical management could differ depending upon the test findings. All genes on this panel have been implicated in cancer predisposition and are associated with increased lifetime cancer risks, although these risks may differ depending on the particular gene. For many of the genes, specific screening and medical management recommendations are available for individuals with mutations. These genes include but are not limited to: *APC, BMPR1A, BRCA1, BRCA2, CDH1, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, SMAD4, STK11,* and *TP53.* Identification of a mutation in other genes can also impact medical management decisions and more data and specific recommendations are expected to emerge over time. Identification of a mutation in any gene does not imply that cancer screening and risk management options will be covered by health insurance. If mutations are identified in more than one gene on this panel, there may not be sufficient information available to determine my potential cancer risk. Therefore, the results of this genetic test may or may not have implications for my medical management and options including preventive screening/intervention or therapeutics based on my genetic testing result may change over time. Further testing may be needed.
Genetic test results have implications for my family members. If I am found to carry a mutation/variant in any of the genes analyzed, this may also have implications for my family members. This should be discussed with my healthcare provider.

* **There are several types of genetic test results, including:**

* *Positive* - A mutation was identified in a gene associated with increased cancer susceptibility. This may be indicative that I am at an increased risk of developing cancer. The specific type of cancer depends on the particular gene. My healthcare provider will make cancer screening and medical management recommendations based on what is known about the gene in which a mutation was found.

* *Negative* - No mutations were identified in any of the genes tested. This may be indicative of a reduced likelihood that I have a mutation in the genes tested (see limitations of testing). My healthcare provider will make cancer screening and medical management recommendations based on my personal and/or family history. *Variant* - An alteration was identified in one or more genes; however, there is not enough information to determine whether this change is associated with an increased risk for cancer. A thorough review of the variant and the associated literature may suggest if that variant is more likely to be disease-causing or benign. However, in some cases the significance remains unclear. My healthcare provider will make cancer screening and medical management recommendations based on my personal and/or family history.

* Pre-and post-test genetic counseling provided by a qualified specialist, such as a genetic counselor or medical geneticist, is recommended and sometimes required by insurance carriers for individuals undergoing genetic testing.

* I understand that this molecular genetic test may require additional blood, body fluid, or tissue sample to obtain accurate results and could take up to 60 days or more to determine medical necessity, insurance approval and receipt of test results to my health care provider.

Absolute Genomics

Patient Consent for Multi-Gene Cancer Panels

*I understand the following information regarding genetic discrimination:
There are federal laws in place that prohibit health insurers and employers from discriminating based on genetic information, for example, the Genetic Information Nondiscrimination Act (GINA) of 2008 (Public Law 110-233). There are currently no federal laws that prohibit life insurance, long term care, or disability insurance companies from discriminating based on genetic information. My state may have more comprehensive laws in this area. The results of genetic testing are considered protected health information and are confidential to the extent allowed by state and federal law. Release of test results is limited to authorized personnel, such as the ordering physician, and to other parties as required by law. Please reference www.ginahelp.org.

*I understand the following information regarding technical limitations of this testing:
While this test is designed to identify most detectable mutations in the genes analyzed, it is still possible that there are mutations that this testing technology is unable to detect. In addition, there may be other genes associated with cancer susceptibility that are not included on this panel or that are not known at this time.

*I understand the following information regarding standard laboratory limitations:
I understand that inaccurate results may occur as a result of (but not limited to) the following reasons: sample mix-up, samples unavailable from critical family members, inaccurate reporting of family relationships, inaccurate or misleading medical information about my clinical condition or that of my family members, or technical problems. Due to limitations in technology and incomplete knowledge of genes, some changes in DNA or protein products that cause disease, may not be detected by the test. There is a possibility that the result findings will be uninterpretable or of unknown significance.

*I understand that Absolute Genomics / Global Reach Labs reserves the right to:
Suggest additional molecular testing if it would help in resolving my clinical genotyping.
Refuse testing if one of the conditions in this informed consent document is not met.
Report additional testing results (other than requested) if they are clinically relevant to me (the patient) and my family. The methodologies for evaluating specific gene(s) of interest may rarely identify incidental findings related or unrelated to the reason I have been offered testing. In such instances, these results will be discussed with my healthcare provider and additional testing may be recommended and ordered. I understand and acknowledge that by signing this consent I am giving express written approval for my healthcare provider to order additional testing according to the results of the genetic hereditary cancer testing ordered. This approval and consent by the undersigned to further testing is limited to further testing of my genetics related to the original genetic testing for hereditary cancer screening to enhance the complete assessment of my potential hereditary cancer risk.

Patient Acknowledgment: I acknowledge that the information provided by me on the test requisition form and other related documents provided is true and correct for direct insurance/3rd party billing. I also acknowledge that my healthcare provider is sending my information to Absolute Genomics / Global Reach Labs for the purpose of medical consultation by the Molecular Pathologist of Absolute Genomics / Global Reach Labs as an in-network provider with most major insurance carriers but in some cases the lab provider may be out of network. I acknowledge that I have been provided the opportunity to have this test performed with a in-network lab provider. I hereby authorize my insurance benefits to be paid directly to Absolute Genomics / Global Reach Labs and I authorize them to release medical information concerning my testing to my insurer and acknowledge that I am financially responsible for any payment of any deductibles or co-insurance charges for the medical consultation, all lab test or genetic counseling services required by my insurer. I also agree that in a case where my insurance provider sends payment directly to me, I am legally responsible for sending that money to Absolute Genomics / Global Reach Labs. I agree to endorse the insurance check and forward to Absolute Genomics / Global Reach Labs within 30 days. I also authorize Absolute Genomics / Global Reach Labs to be my designated representative for purposes of appealing any denial of benefits as needed. I acknowledge that Absolute Genomics / Global Reach Labs has the right to request additional medical records such as consult notes, pedigrees, and clinical/family history notes directly from my provider(s) for the purposes of medical consultation and insurance verification and billing.

I have read or have had read to me all of the above statements and understand the information regarding molecular genetics testing and have had the opportunity to ask questions that I might have about the testing, procedure, the risks, and alternatives prior to my informed consent. My signature below acknowledges my voluntary participation in this molecular genetic testing and such genetic analysis in no way guarantees my health, the health or the health of other family members.

_____ _____

Patient Signature (or Parent/Guardian if patient is a minor) Date

_____

Patient Name *(Print)*

_____

Name and Relationship *(Parent/Guardian if patient is a minor)*

Absolute Genomics

INSURANCE ORDERING CHECKLIST

1. Patients Name with a copy of Demographic/FACE sheet
2. Check appropriate panel type
3. Copy of Patient's insurance card
4. Include ALL applicable diagnosis codes
5. PROVIDER NOTES: "CGx done today; will follow up when results are reported"
6. Patient and Physician names and signatures

PATIENT INFORMATION

First name | MI | Last name | Date of Birth MM/DD/YYYY

Biological sex: ○ Male ○ Female

MRN (medical record number)

Ancestry: ○ Asian ○ Black/African American ○ White/Caucasian ○ Ashkenazi Jewish ○ Hispanic ○ Native American ○ Pacific Islander ○ French Canadian ○ Sephardic Jewish ○ Mediterranean ○ Other: _____

Email address (for report access after release by medical professional) | Phone

Address

City | State | ZIP code | Country

ORGANIZATION INFORMATION

Organization name		Phone	Fax	
Address	City	State/Prov	ZIP/Postal Code	Country

CLINICAL TEAM

Primary clinical contact (contact for general inquires)

Name	NPI	Email address (for report access)

Ordering physician ○ Same as primary clinical contact

Additional clinical or laboratory contacts (optional; share online access to this order with the contacts below)

○ Share this order with the primary clinical contact's default clinical team

Name	Email address (for report access)	Name	Email address (for report access)
Name	Email address (for report access)	Name	Email address (for report access)

● INSURANCE BILLING (attach front and back of insurance card) ● PATIENT PAY BILLING

Attach clinical notes, medical records, and/or letter of medical necessity (LMN) to prevent delays. We do not accept insurance for certain tests *or* patients outside the US.

Policyholder name	Patient relationship to policyholder ○ Self ○ Spouse ○ Child ○ Other: _____		**ICD-10 code required** Indicate Below
Primary insurance company name	Primary member ID#	Primary insurance phone	Primary prior-authorization #
Secondary insurance company name	Secondary member ID#	Secondary insurance phone	Secondary prior-authorization #

ICD-10 codes (required for insurance billing): _____ _____ _____ _____ _____ _____ _____

SPECIMEN INFORMATION

Label each tube with the patient's full name and date of birth. A requisition form MUST accompany each specimen.

Collection Date MM/DD/YYYY

If not provided, date will be 1 day prior to our receipt of specimen. For DNA, provide date retrieved from archive.

Specimen type ○ Buccal Swab ○ Other _____ ○ Saliva

DNA must be extracted in a CLIA or other suitably certified laboratory. We are unable to accept blood or saliva from patients with allogeneic bone marrow transplants or a blood transfusion <2 weeks prior to specimen collection.

Collection Time:

Absolute Genomics

Patient's first name | Patient's last name

HEREDITARY CANCER TEST CATALOG

Ordering Provider; Hereditary cancer personal and family history risk assessment order:

I, the ordering provider listed on this form, completed a full assessment of the patient's personal/family history of cancer and find a need for further in-depth cancer risk evaluation on, but not limited to, the marked cancers below in this section and am (1) requesting that my patient receive genetic counseling and if subsequent genetic testing is deemed appropriate by a qualified, independent genetic counselor according to all applicable guidelines, including but not limited to NCCN/insurance carrier medical policy testing and am (2) authorizing a qualified, independent genetic counselor to facilitate the completion of the gene(s)and/or panel selection of this test requisition form and submit any prior authorization, if necessary, on my behalf utilizing my name and NPI provided here within. The gene(s)/ test panel selected must match the recommendation provided to myself and the patient in the official report from the genetic counselor that is placed in the patient's medical chart. I have personally signed this individual test order form. I understand that any genetic testing performed on my patient will be my responsibility and ordered in my name.

○ I agree with the above consent for mutual collaboration with a qualified genetic counselor to perform an in-depth review, patient education, and evidence based determination of testing in order to reduce the cost of unnecessary testing.

PLEASE SELECT APPROPRIATE CANCERS BELOW ACCORDING TO PERSONAL AND FAMILY INDICATIONS REPORTED DURING PATIENT'S EXAM

○	Breast Cancer	○	Pancreatic Cancer	○	Kidney / Renal Cancer	○	Colorectal Polyps	○	Lung Cancer	○	Leukemia
○	Ovarian Cancer	○	Prostate Cancer	○	Gastric Cancer	○	Melanoma	○	Thyroid Cancer	○	Brain Tumor
○	Colorectal Cancer	○	Uterine Cancer	○	Endometrial Cancer	○	Lynch Syndrome	○	Sarcoma	○	Carcinoma

Frequently Ordered Hereditary Cancer Panels

Test code	Test name	# Gene(s)	
○	**Comprehensive Gene Panel**	49	BRCA1, BRCA2, APC, CDH1, MLH1, MSH2, MSH6, PTEN, STK11, SMAD4, MUTYH, BMPR1A, TMEM127, MAX, SDHB, SDHC, SDHD, VHL, ATM, NF1, NF2, PALB2, PMS2, CDKN2A, TP53, TSC2, FH, PHOX2B, MEN1, RET, SDHA, TSC1, NSD1, WT1, CASR, BARD1, BRIP1, CDK4, CHEK2, DICER1, EPCAM, MRE11A, NBN, POLD1, POLE, RAD50, RAD51C, RAD51D, SMARCB1

HEREDITARY CANCER INDIVIDUAL GENES

○ APC	○ CASR	○ FH	○ MUTYH	○ PMS2	○ RET	○ STK11
○ ATM	○ CDH1	○ MAX	○ NBN	○ POLD1	○ SDHA	○ TMEM127
○ BARD1	○ CDK4	○ MEN1	○ NF1	○ POLE	○ SDHB	○ TP53
○ BMPR1A	○ CDKN2A	○ MLH1	○ NF2	○ PTEN	○ SDHC	○ TSC1
○ BRCA1	○ CHEK2	○ MRE11A	○ NSD1	○ RAD50	○ SDHD	○ TSC2
○ BRCA2	○ DICER1	○ MSH2	○ PALB2	○ RAD51C	○ SMAD4	○ VHL
○ BRIP1	○ EPCAM	○ MSH6	○ PHOX2B	○ RAD51D	○ SMARCB1	○ WT1

By signing this form, the medical professional acknowledges that the individual/family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo genetic testing, as stated in the Absolute Genomics / Global Reach Labs Informed Consent for Genetic Testing. The Patient has been informed that a licensed health care professional from Absolute Genomics / Global Reach Labs may contact them to gather missing personal & family medical history to assist in providing complete information to the ordering medical professional & independent licensed genetic counselor in determining medical necessity and notify them of clinical updates related to genetic test results (in consultation with the ordering medical professional as indicated), The Patient has further been informed and authorizes Absolute Genomics / Global Reach Labs and its designees to release information concerning testing to their insurer, if applicable, to process and/or appeal claims on behalf of the Patient. If a letter of medical necessity (LMN) has not been provided, the medical professional agrees to allow Absolute Genomics / Global Reach Labs to transfer the information from this requisition to an LMN and/or other documentation using the medical professional's name as the signature for insurance billing. For amounts received directly, the Patient has agreed to remit payment to Absolute Genomics / Global Reach Labs for testing services rendered. I acknowledge and take full responsibility that the Patient has been informed and agreed that if the Patient's insurer does not reimburse I acknowledge that the Patient has been informed and understands that Absolute Genomics / Global Reach Labs may be potentially out of network and was given the option to have this test performed with an in-network lab provider. The patient agreed that if the Patient's insurer does not reimburse Absolute Genomics / Global Reach Labs in full for any reason, including if the insurer considers the genetic test ordered to be a non-covered service or not medically necessary, then Absolute Genomics / Global Reach Labs may bill the patient directly for the services and the Patient will remit payment directly to Absolute Genomics / Global Reach Labs. I understand this consent includes a referral for pre-genetic counseling which is required before all hereditary cancer genetic testing. I, the referring provider listed on this form, am (1) requesting that my patient receive genetic counseling and if deemed appropriate by a qualified independent genetic counselor, subsequent genetic testing; and am (2) authorizing a certified genetic counselor to facilitate the completion of any test requisition forms and/or submit any prior authorization, if necessary, on my behalf utilizing my name and NPI. I understand that any genetic testing performed on my patient will be my responsibility and ordered in my name. I understand that this test will not be rendered if the patient does not attend the required genetic counseling or otherwise meet the requirements for genetic testing. I understand that completion of this process and a report of results may take up to 60 days.

Medical professional signature (required) **Date**