

FEMALE PATIENT     MALE PATIENT

LAST NAME \_\_\_\_\_

FIRST NAME \_\_\_\_\_

PATIENT ID NUMBER \_\_\_\_\_

DATE OF BIRTH (MM/DD/YYYY) \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_

ETHNICITY  Asian     African American     Hispanic  
 Caucasian     Jewish, Ashkenazi     Other/Mixed/Unknown \_\_\_\_\_

E-MAIL \_\_\_\_\_

STREET NUMBER \_\_\_\_\_ STREET NAME \_\_\_\_\_ APT NUMBER \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**ACKNOWLEDGEMENT:** I authorize the laboratory to provide to my health plan the information on this form and other information provided by my healthcare provider if necessary for reimbursement. I understand that the laboratory may seek prior authorization for testing from my health plan on my behalf. I also authorize all benefits of the plan to be payable directly to the laboratory, and I agree to remit to the laboratory any payment for these services made directly to me. I understand that the laboratory may be an out-of-network provider for my health plan and that I am responsible for all amounts not reimbursed by my health plan. I hereby designate the laboratory as my Authorized Representative, as provided under ERISA, 29 C.F.R. § 2560.5031(b)(4), and/or as my Attorney in Fact, for the purpose of pursuing administrative appeals to which I am entitled and, if the laboratory deems it appropriate, any legal and/or equitable claims that I could bring against my health plan, and/or its fiduciaries, and/or its administrators, with respect to their handling or resolution of my insurance claim.

I authorize the laboratory to retain and use my de-identified specimen and test data (where all information that could link me to the specimen or data has been removed) for research and/or help develop new products or services, in compliance with applicable laws.

I do not authorize the laboratory to retain and use my de-identified specimen and test data as described above.

All leftover specimens from New York State will be destroyed within 60 days.

**REQUIRED** **PATIENT SIGNATURE** \_\_\_\_\_ DATE (MM/DD/YY) \_\_\_\_\_

**SPECIMEN INFO** Collected on: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM

Collected by: \_\_\_\_\_

**Collection Requirement Key:** See Specimen Guide for additional specimen types

4 mL Lavender-top EDTA tube    OR    ORACollect® buccal swab    OR    15mL mouthwash

**CLINICIAN INFO**

ORDERING CLINICIAN SIGNATURE \_\_\_\_\_ DATE (MM/DD/YY) \_\_\_\_\_

GENETIC COUNSELOR NAME / NPI# \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_ FAX NUMBER \_\_\_\_\_

E-MAIL \_\_\_\_\_

ADDITIONAL REPORTS TO: CLINICIAN NAME \_\_\_\_\_

NPI# \_\_\_\_\_ FAX NUMBER \_\_\_\_\_

**ACKNOWLEDGEMENT:** I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given consent as required under applicable laws and regulations for the test(s) to be performed. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purposes for this patient. I confirm that the person listed as the Ordering Clinician is authorized by law to order the test(s) requested herein.

**REQUIRED** **ORDERING CLINICIAN SIGNATURE** \_\_\_\_\_ DATE (MM/DD/YY) \_\_\_\_\_

GENETIC COUNSELOR NAME / NPI# \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_ FAX NUMBER \_\_\_\_\_

E-MAIL \_\_\_\_\_

ADDITIONAL REPORTS TO: CLINICIAN NAME \_\_\_\_\_

NPI# \_\_\_\_\_ FAX NUMBER \_\_\_\_\_

**BILLING INFO**

**BILL INSURANCE** Attach legible front and back copy of insurance card(s).

INSURANCE COMPANY \_\_\_\_\_

MEMBER ID \_\_\_\_\_

**BILL PATIENT / DO NOT BILL INSURANCE** Patient will be contacted to provide payment method.

**BILL ORDERING CLINICIAN**

**TEST REQUESTED (SEE DESCRIPTIONS ON REVERSE)**

**4200 Riscover® Hereditary Cancer Test**

**Indication (choose one)** *Test ordered will be processed and billed based upon payer criteria*

**HBOC** (Hereditary breast and ovarian cancer syndrome)  
*Associated cancers: Breast, Ovarian, Pancreatic, Prostate*

**Lynch syndrome**  
*Associated cancers: Colorectal, Uterine/Endometrial*

**Polyposis syndrome**  
*Associated: Polyps, Colorectal cancer*

Other hereditary cancer risk: \_\_\_\_\_

**4210 Riscover® BRCA Ashkenazi Jewish Three-Site Analysis**

Reflex to Riscover® Hereditary Cancer Test if negative

**Known Family Variant** Gene: \_\_\_\_\_ Variant: \_\_\_\_\_

*A copy of the affected relative's result report is required.*

Full name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Check if this testing is for the Variant Classification Program (only the familial variant of uncertain significance will be tested)

**Other:** \_\_\_\_\_

**REQUISITION CHECKLIST**

**FAMILY HISTORY COLLECTED USING:** **REQUIRED**

Cancer Compass (attach form, both sides)

Online risk assessment (attach report)

ICD-10 diagnosis code(s) **REQUIRED**

Patient's insurance card (legible front and back copy) **REQUIRED**

Patient clinical history (if personal history of cancer)

Genetic counseling visit notes (if performed)

Results for any previous genetic or tumor testing

**PATIENT CLINICAL HISTORY**

**REQUIRED** **Has patient ever been diagnosed with cancer?**

**YES** – complete the section below.     **NO**

**BREAST CANCER** Age at dx: \_\_\_\_\_ Pathology: \_\_\_\_\_

left     pre-menopausal     ductal invasive  
 right     post-menopausal     lobular invasive  
 bilateral     DCIS  
 other: \_\_\_\_\_

Triple negative? (ER-, PR-, Her2/neu-)  YES  NO

**OVARIAN CANCER** Age at dx: \_\_\_\_\_ Pathology: \_\_\_\_\_

**UTERINE / ENDOMETRIAL CANCER** Age at dx: \_\_\_\_\_ Pathology: \_\_\_\_\_

Was tumor screening performed?  YES  NO  
*If "Yes," attach results.*

**PROSTATE CANCER** Age at dx: \_\_\_\_\_ Gleason score: \_\_\_\_\_ Metastatic?  YES  NO

**COLORECTAL CANCER** Age at dx: \_\_\_\_\_ Location:  colon  rectum Pathology: \_\_\_\_\_

Was tumor screening performed?  YES  NO  
*If "Yes," attach results.*

**GI POLYPS** Age at dx: \_\_\_\_\_ Number of polyps: \_\_\_\_\_ Pathology:  adenomatous  other type: \_\_\_\_\_

**HEMATOLOGIC CANCER** Age at dx: \_\_\_\_\_ Pathology: \_\_\_\_\_

Was bone marrow or stem cell transplant performed?  YES  NO

**OTHER CANCER** Age at dx: \_\_\_\_\_ Type: \_\_\_\_\_

**REQUIRED** ICD-10 Code(s) \_\_\_\_\_ *Commonly used codes are listed on the reverse.*

**ADDITIONAL CLINICAL INFO**

**PREVIOUS CANCER GENETIC TESTING**

No previous testing

Testing performed: *Attach results if available.*

gene(s) tested: \_\_\_\_\_

results: \_\_\_\_\_

**GENETIC COUNSELING**

Genetic counseling with ordering provider

Genetic counseling with independent certified GC

Date of GC visit: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

*Please attach GC visit note.*

**Riscover® Hereditary Cancer Test**

Analysis of *APC, ATM, BARD1, BMPR1A, BRCA1, 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*

**Riscover® BRCA Ashkenazi Jewish Three-Site Analysis**

Targeted analysis of three mutations: *BRCA1* c.68\_69delAG; *BRCA1* c.5266dupC; *BRCA2* c.5946delT

**FAMILY HISTORY OF CANCER**

Family history of malignant neoplasm of digestive organs (colon, stomach, intestine, pancreas).....	Z80.0
Family history of malignant neoplasm of breast.....	Z80.3
Family history of malignant neoplasm of ovary.....	Z80.41
Family history of malignant neoplasm of prostate.....	Z80.42
Family history of malignant neoplasm of other genital organs (uterus, endometrium).....	Z80.49
Family history of malignant neoplasm of kidney.....	Z80.51
Family history of malignant neoplasm of the bladder.....	Z80.52
Family history of malignant neoplasm of other organs or systems.....	Z80.8
Family history of malignant neoplasm, unspecified.....	Z80.9
Family history of colonic polyps.....	Z83.71
Family history of carrier of genetic disease.....	Z84.81

**PERSONAL HISTORY OF CANCER**

Personal history of malignant carcinoid tumor of large intestine (colon).....	Z85.030
Personal history of other malignant neoplasm of large intestine (colon).....	Z85.038
Personal history of malignant carcinoid tumor of rectum.....	Z85.040
Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus.....	Z85.048
Personal history of malignant neoplasm of pancreas.....	Z85.07
Personal history of malignant neoplasm of breast.....	Z85.3
Personal history of malignant neoplasm of other parts of uterus (endometrium).....	Z85.42
Personal history of malignant neoplasm of ovary.....	Z85.43
Personal history of malignant neoplasm of prostate.....	Z85.46
Personal history of in-situ neoplasm of breast.....	Z86.000
Personal history of colonic polyps.....	Z86.010

**BREAST CANCER – MALIGNANT NEOPLASM**

*Use additional code to identify estrogen receptor status (Z17.0, Z17.1)*

Malignant neoplasm of nipple and areola, right female breast.....	C50.011
Malignant neoplasm of nipple and areola, left female breast.....	C50.012
Malignant neoplasm of nipple and areola, unspecified female breast.....	C50.019
Malignant neoplasm of central portion of right female breast.....	C50.111
Malignant neoplasm of central portion of left female breast.....	C50.112
Malignant neoplasm of central portion of unspecified female breast.....	C50.119
Malignant neoplasm of upper-inner quadrant of right female breast.....	C50.211
Malignant neoplasm of upper-inner quadrant of left female breast.....	C50.212
Malignant neoplasm of upper-inner quadrant of unspecified female breast.....	C50.219
Malignant neoplasm of lower-inner quadrant of right female breast.....	C50.311
Malignant neoplasm of lower-inner quadrant of left female breast.....	C50.312
Malignant neoplasm of lower-inner quadrant of unspecified female breast.....	C50.319
Malignant neoplasm of upper-outer quadrant of right female breast.....	C50.411
Malignant neoplasm of upper-outer quadrant of left female breast.....	C50.412
Malignant neoplasm of upper-outer quadrant of unspecified female breast.....	C50.419
Malignant neoplasm of lower-outer quadrant of right female breast.....	C50.511
Malignant neoplasm of lower-outer quadrant of left female breast.....	C50.512
Malignant neoplasm of lower-outer quadrant of unspecified female breast.....	C50.519
Malignant neoplasm of axillary tail of right female breast.....	C50.611
Malignant neoplasm of axillary tail of left female breast.....	C50.612
Malignant neoplasm of axillary tail of unspecified female breast.....	C50.619
Malignant neoplasm of overlapping sites of right female breast.....	C50.811
Malignant neoplasm of overlapping sites of left female breast.....	C50.812
Malignant neoplasm of overlapping sites of unspecified female breast.....	C50.819

**BREAST CANCER – CARCINOMA IN SITU**

Carcinoma in situ of breast.....	D05
Lobular carcinoma in situ of right breast.....	D05.01
Lobular carcinoma in situ of left breast.....	D05.02
Lobular carcinoma in situ of unspecified breast.....	D05.09
Intraductal carcinoma in situ of right breast.....	D05.11
Intraductal carcinoma in situ of left breast.....	D05.12
Intraductal carcinoma in situ of unspecified breast.....	D05.19
Other carcinoma in situ of right breast.....	D05.71
Other carcinoma in situ of left breast.....	D05.72
Other carcinoma in situ of unspecified breast.....	D05.79
Unspecified carcinoma in situ of right breast.....	D05.91
Unspecified carcinoma in situ of left breast.....	D05.92
Unspecified carcinoma in situ of unspecified breast.....	D05.99

**OVARIAN CANCER**

Malignant neoplasm of right ovary.....	C56.0
Malignant neoplasm of left ovary.....	C56.1
Malignant neoplasm of ovary, unspecified side.....	C56.9

**UTERINE CANCER**

Malignant neoplasm of isthmus uteri.....	C54.0
Malignant neoplasm of endometrium.....	C54.1
Malignant neoplasm of fundus uteri.....	C54.3
Malignant neoplasm of overlapping sites of corpus uteri.....	C54.8
Malignant neoplasm of corpus uteri, unspecified.....	C54.9

**COLORECTAL CANCER**

Malignant neoplasm of cecum.....	C18.0
Malignant neoplasm of appendix.....	C18.1
Malignant neoplasm of ascending colon.....	C18.2
Malignant neoplasm of hepatic flexure.....	C18.3
Malignant neoplasm of transverse colon.....	C18.4
Malignant neoplasm of splenic flexure.....	C18.5
Malignant neoplasm of descending colon.....	C18.6
Malignant neoplasm of sigmoid colon.....	C18.7
Malignant neoplasm of overlapping sites of colon.....	C18.8
Malignant neoplasm of colon, unspecified.....	C18.9
Secondary malignant neoplasm of large intestine and rectum.....	C78.5

**BENIGN COLORECTAL NEOPLASMS**

Benign neoplasm of cecum.....	D12.0
Benign neoplasm of appendix.....	D12.1
Benign neoplasm of ascending colon.....	D12.2
Benign neoplasm of transverse colon.....	D12.3
Benign neoplasm of descending colon.....	D12.4
Benign neoplasm of sigmoid colon.....	D12.5
Benign neoplasm of colon, unspecified.....	D12.6
Benign neoplasm of rectosigmoid junction.....	D12.7
Benign neoplasm of rectum.....	D12.8
Benign neoplasm of anus and anal canal.....	D12.9

**PERITONEAL CANCER**

Malignant neoplasm of retroperitoneum.....	C48.0
Malignant neoplasm of specified parts of peritoneum.....	C48.1
Malignant neoplasm of peritoneum, unspecified.....	C48.2
Malignant neoplasm of overlapping sites of retroperitoneum and peritoneum.....	C48.8

**PANCREATIC CANCER**

Malignant neoplasm of head of pancreas.....	C25.0
Malignant neoplasm of body of pancreas.....	C25.1
Malignant neoplasm of tail of pancreas.....	C25.2
Malignant neoplasm of pancreatic duct.....	C25.3
Malignant neoplasm of endocrine pancreas.....	C25.4
Malignant neoplasm of other parts of pancreas.....	C25.7
Malignant neoplasm of overlapping sites of pancreas.....	C25.8
Malignant neoplasm of pancreas, unspecified.....	C25.9