Test Requisition Form for Hereditary Genetic Analysis

Please Fax to 877-764-7628

6555 Sanger Rd Suite 260, Orlando FL 32827

CAP ID#: 8832145 | CLIA ID#: 10D2192649
CDPH ID#: CDS-90005103 | PA LAB ID#: 39259

Medical Director: Anthony Magliocco MD, FCAP

PROTEAN BIODIAGNOSTICS

Customer Service: 1 (754) 242 9682
or support@proteanbiodx.com

Patient Information

Name (Last, First, MI)			
DOB (MM/DD/YYYY)	☐Female (XX) ☐Male (XY) ☐Other__________ (X__)	Phone (primary)	
Street Address			
City	State	Postal Code	Country
Patient Email Address			
MRN (Medical Record Number)			

Authorized Provider Information

Provider's NPI #			Fax
Office / Practice / Institution		Provider's Email	
Street Address			
City	State	Postal Code	Country
Office Contact Name	Contact Phone	Contact Email	
Specimen Collected by / Location: *(please check off correct response)*	☐ Patient / Home Address Listed to Left ☐ Provider / Location Listed Above		

Insurance Billing Information

Please send image of front and back of all insurance.

ICD-10 Codes (List all ICD-10 codes below)

Cancer Type (list cancer type below)

Specimen Information

Specimen Type	Collection Date (MM/DD/YYYY)	Is this meant to replace a previously submitted sample?
☐ Swab		☐ **Yes**, this is a replacement sample ☐ **No**, this is **not** a replacement

Note: • Label tube with the patient's full name, DOB, & collection date. • A requisition form is required for each specimen.

Risk MAPS™ Panel Options (For a full list of genes covered, please refer to www.proteanbiodx.com/risk-panels)

☐ Breast & Ovarian Cancer Risk Panel: *38 Genes*	☐ Pancreatic Cancer Risk Panel: *23 Genes*
☐ Colorectal Cancer Risk Panel: *27 Genes*	☐ Prostate Cancer Risk Panel: *19 Genes*
☐ Gastric Cancer Risk Panel: *32 Genes*	☐ Combined Hereditary Cancer Risk Panel: *62 Genes*
☐ **Total Comprehensive Cancer Risk Panel:** *135 Genes*	

Additional Panel Options: ☐ Pharmacogenetics ☐ Polygenetic Risk Scores

Special Requests

Collection Tube Barcode

Certificate of Medical Necessity, Consent, Test Authorization, and Physician Signature

By signing this form the medical professional acknowledges that the individual authorized to make decisions for the patient (Collectively as, the "Patient") has been supplied with all information regarding risks and has consented to have genetic testing performed as set forth in Protean's Informed consent. For orders outside of the US, the Patient has been informed their personal health information and sample will be processed in the US. The Patient has been informed that Protean may notify them of clinically relevant updates related to their genetic testing results (in consultation with ordering professional). The medical professional acknowledges that pretest and post test genetic counseling are required by the state of Florida for labs performing genetic analysis. The medical professional agrees to allow Protean to transfer the information from this test requisition form to a letter of medical necessity and/or other documents using the medical professionals name as the signature. I acknowledge that the Patient has agreed that if the Patient's insurer does not reimburse Protean in full for any reason then Protean may bill the Patient for the services rendered and the Patient will remit payment to Protean. For amounts that the Patient receives from their insurer, the Patient has agreed to remit payment to Protean for services rendered. I acknowledge that I offered pre-test counseling, or arranged for it to be performed, as required by Florida law and applicable insurance. I hereby attest that I am authorized under applicable law to order this test.

Ordering Physician Signature ____________________ Date ____________

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Patient History of Cancer / Clinical Information

Patient Diagnosis	Age at Diagnosis	Additional Information
☐ Breast Cancer		☐ TNBC (Triple Negative Breast Cancer) ☐ DCIS (Ductal Carcinoma in Situ) ☐ ILC (Invasive Lobular Carcinoma) ☐ IDC (Invasive Ductal Carcinoma) ☐ Bilateral ☐ Other Info:
☐ Colon / Rectal Cancer		
☐ Colon / Rectal Polyps		Cumulative Polyp ☐ 1-9 ☐ 10-19 ☐ 20-99 ☐ 100+ Polyp Pathology:
☐ Pancreatic Cancer		
☐ Prostate Cancer		☐ Metastatic Gleason Score: ______
☐ Endometrial / Uterine Cancer		☐ Tumor is IHC Abnormal or Tumor is MSI-high Results: ______
☐ Ovarian / Fallopian Tube / Peritoneal Cancer		
☐ Lung Cancer		
☐ Other: ______		

Family History of Cancer

Relation to Patient	Age at Diagnosis	Cancer Type
☐ Maternal ☐ Paternal		
☐ Maternal ☐ Paternal		
☐ Maternal ☐ Paternal		
☐ Maternal ☐ Paternal		

Previous Genetic Testing

Has the patient previously received genetic testing?

☐ No ☐ Yes (indicate type): ______

Shipping Information

Please follow instructions in the box, and use the enclosed prepaid envelope to ship kit to: **Protean BioDiagnostics 6555 Sanger Road Suite 260, Orlando FL 32827**	Email: support@proteanbiodx.com Phone: 1 (754) 242 9682

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