

CANCER DNA TEST REQUISITION

SHIP TO: MEDICAL GENETICS LABORATORIES

Baylor College of Medicine
2450 Holcombe, Grand Blvd. - Receiving Dock
Houston, TX 77021-2024

!STOP IMPORTANT BILLING INFORMATION!

Indicate Institution Billing Code here: _____, **OR**
complete and fax billing information form (page 2 of requisition)
to 713-798-4187. **Samples received without the Institution
Code or Billing Form cannot be processed.**

FOR PRENATALS, PLEASE USE PRENATAL REQUISITION FORM.

PATIENT DATA

NAME (Last, First, Middle Initial): _____
DATE OF BIRTH (MM/DD/YY): ____/____/____
Please check one: MALE FEMALE UNKNOWN
HOSPITAL #: _____
ACCESSION #: _____

REPORTING INFORMATION

PHYSICIAN/INSTITUTION: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE #: (____) _____ FAX #: (____) _____
Additional Reports to:
1. NAME: _____ FAX #: (____) _____

COMPLETE A FORM FOR EACH SAMPLE SUBMITTED.

SAMPLE INFORMATION

DATE SAMPLE OBTAINED (MM/DD/YY): ____/____/____

SPECIMEN TYPE: Blood Tissue Block Other (Specify): _____

INDICATION FOR TESTING:

Symptomatic/Clinical Findings (summarize): _____

of colon polyps: _____

Family History: Mutation Known? Yes No

If yes, attach report with signed authorization form (see web site). Positive control DNA sample may be required in some cases.

In addition, please provide Family History/Pedigree on back of form. Identify the patient with an arrow.

Other: _____

ETHNIC BACKGROUND: EUROPEAN CAUCASIAN ASHKENAZIC JEWISH OTHER JEWISH ASIAN HISPANIC

AFRICAN AMERICAN NATIVE AMERICAN INDIAN OTHER: _____

IMPORTANT: Check The Test(s) Requested

6087	<input type="checkbox"/> Familial Adenomatous Polyposis (FAP) - APC Full Sequencing
6086	<input type="checkbox"/> Familial Adenomatous Polyposis (FAP) - APC Deletion/Duplication Assay
6089	<input type="checkbox"/> Familial Adenomatous Polyposis (FAP) - Known Familial Mutation (specify: _____)
6094	<input type="checkbox"/> Hereditary Non-Polyposis Colon Cancer (HNPCC) Panel (MLH1, MSH2, MSH6 Sequencing)
6098	<input type="checkbox"/> Hereditary Non-Polyposis Colon Cancer (HNPCC) Screening MSI & IHC
6095	<input type="checkbox"/> Hereditary Non-Polyposis Colon Cancer (HNPCC) - MLH1 Full Sequencing
6142	<input type="checkbox"/> Hereditary Non-Polyposis Colon Cancer (HNPCC) - MLH1 Sequencing - Known Familial Mutation (specify: _____)
6116	<input type="checkbox"/> Hereditary Non-Polyposis Colon Cancer (HNPCC) - MLH1 Deletion/Duplication Assay
6146	<input type="checkbox"/> Hereditary Non-Polyposis Colon Cancer (HNPCC) - MLH1 Deletion/Duplication Assay - Known Familial Mutation (specify: _____)
6096	<input type="checkbox"/> Hereditary Non-Polyposis Colon Cancer (HNPCC) - MSH2 Full Sequencing
6143	<input type="checkbox"/> Hereditary Non-Polyposis Colon Cancer (HNPCC) - MSH2 Sequencing - Known Familial Mutation (specify: _____)
6117	<input type="checkbox"/> Hereditary Non-Polyposis Colon Cancer (HNPCC) - MSH2 Deletion/Duplication Assay
6147	<input type="checkbox"/> Hereditary Non-Polyposis Colon Cancer (HNPCC) - MSH2 Deletion/Duplication Assay - Known Familial Mutation (specify: _____)
6097	<input type="checkbox"/> Hereditary Non-Polyposis Colon Cancer (HNPCC) - MSH6 Full Sequencing
6144	<input type="checkbox"/> Hereditary Non-Polyposis Colon Cancer (HNPCC) - MSH6 Sequencing - Known Familial Mutation (specify: _____)
6118	<input type="checkbox"/> Li-Fraumeni Syndrome (LFS) P53 Full Sequencing
6119	<input type="checkbox"/> Li-Fraumeni Syndrome (LFS) Known Familial Mutation (specify: _____)
6104	<input type="checkbox"/> MYH Associated Polyposis Mutation Panel (2 mutations)
6120	<input type="checkbox"/> MYH Associated Polyposis Full Sequencing
6103	<input type="checkbox"/> MYH Associated Polyposis Known Familial Mutation (specify: _____)
3600	<input type="checkbox"/> PHEO and PGL-Associated Syndromes Panel SDHB, SDHC, & SDHD
6121	<input type="checkbox"/> Rothmund Thompson Syndrome (RTS) RECQL4 Sequencing
6122	<input type="checkbox"/> Rothmund Thompson Syndrome (RTS) Known Familial Mutation (specify: _____)

KFM - Known Familial Mutation; Seq - Sequencing; Del/Dup - Deletion Duplication

ALL TESTS ARE SUBJECT TO CHANGE - PLEASE SIGN AND INCLUDE THE CONSENT FORM (PAGE 3).

BILLING INFORMATION FORM

STOP! ONE OF THE THREE FOLLOWING BILLING OPTIONS MUST BE INDICATED BELOW.
The Self-Pay option must include payment with sample. We require and provide insurance pre-verification service. Please fax the *Patient Insurance Verification Form* (available at www.bcmgeneticlabs.org) to 713-798-4187. If the Billing Information section is incomplete, the referring physician, hospital, or laboratory will automatically be billed, or sample processing suspended. Please forward billing questions to: medgenbilling@bcm.edu

PATIENT INFORMATION:

Name (Last, First, Middle Initial): _____
Address: _____
City, State, Zip: _____
Phone #: (____) _____ Email: _____

PAYMENT OPTIONS:

1. **Institution or referring MD Code (as assigned by BCM):** _____
(or) Institution Name: _____
Billing Address: _____
City, State, Zip: _____
Financial Contact: _____
E-mail (required): _____
Phone #: (____) _____ Fax #: (____) _____

2. **Self-Pay: Check, Money Order, or Credit Card payment must accompany sample.**
Credit Card (Please check one): AMEX Discover MC VISA
Valid Card #: _____ Exp date (mm/yy): ____/____ **CVC Code:** _____
Cardholder printed name: _____
Cardholder signature: _____

3. **Insurance:** Please refer to the Financial Policy at <http://www.bcm.edu/geneticlabs/billing.html> for complete insurance filing information and managed care contract list. Insurance is filed to our contracted carriers as a courtesy. Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. HMO policies must have required authorizations. We do not file out-of-state Medicaid. Prenatal CMA requires a prepayment amount. Contact medgenbilling@bcm.edu with questions.

ICD9 Diagnosis Code(s) must be provided or insurance cannot be filed: **ICD-9 CODE:** _____
 PPO, Commercial Insurance-provide Patient Insurance Verification form (PIVF) and front/back copy of card
 HMO-provide PIVF, authorization, front/back copy of insurance card
 Texas Medicaid/Texas Medicaid HMO-provide PIVF, authorization, front/back copy of Medicaid card

Insured Policyholder's Information:

Name: _____ Date Of Birth (mm/dd/yy): ____/____/____
Insured SS or ID #: _____ Gender (Please check one): M F
Authorization: _____
Relationship to Patient: _____
Insurance Name: _____
Employer: _____ Group #: _____
Insurance Address: _____
Insurance City, State, Zip: _____
Insurance Phone #: (____) _____

I authorize BCM Medical Genetics Laboratories to furnish any medical information requested on myself, or my covered dependents. In consideration of services rendered, I transfer and assign any benefits of insurance to BCM Medical Genetics Laboratories. I understand I am responsible for any co-pay, deductible, or non-covered service amounts. I understand I am fully responsible for payment of my account if the BCM Medical Genetics Laboratories is not a participant with my health plan, and my health plan does not fully reimburse my medical services due to lack of authorization or medical necessity.

Printed Name: _____

Signature: _____ Date (mm/dd/yy): ____/____/____

INFORMED CONSENT FOR DNA TESTING

I, _____, hereby agree to participate in testing for (name of disease) _____, using a DNA-based test. I understand that samples of blood will be drawn from me and/or members of my family by removing blood from a vein, a procedure which carries very little risk. In addition, if prenatal diagnosis is involved, fetal cells obtained by amniocentesis or chorion villus sampling will be used. I understand that the blood and fetal samples will be used for the purpose of attempting to determine if I and members of my family are carriers of the disease gene, or are affected with, or at increased risk to someday be affected with this genetic disease. In addition, I hereby give permission to collect blood samples from my minor children, named below, to be used for DNA testing for the disease listed above.

Child's Name	Date of Birth (mm/dd/yy)	Sex
_____	___/___/___	_____
_____	___/___/___	_____

I understand that:

1. In some cases the DNA test directly detects an abnormality, called a mutation, in the gene, and the test is >99% accurate. In other cases, an indirect method called linkage analysis is used. If linkage analysis is being used, naturally occurring rearrangements in the DNA (recombination) may produce an uncertainty in predicting carrier status of diagnosis. Rare variations in the DNA of individuals can also cause uncertainty in predicting carrier status of diagnosis. Thus, the test is not 100% accurate, and the results will be reported as a probability.
2. In some families, the markers may not be informative. If this is the case, this DNA test can not provide results for that family, or for some members of that family.
3. An error in the diagnosis may occur if the true biological relationships of the family members involved in this study are not as I have stated. For example, non-paternity means that the father of an individual is not the person stated to be the father. This test may detect non-paternity, and it may be necessary to report this finding to the individual who requested testing.
4. Any erroneous diagnosis in a family member can lead to an incorrect diagnosis for other related individuals in question. I understand that the DNA analysis performed at Baylor College of Medicine for this disease is specific only with respect to it and in no way guarantees my health or the health of my unborn child. The accuracy of DNA analysis is entirely dependent on the clinical diagnosis made elsewhere, and Baylor College of Medicine cannot be responsible for erroneous clinical diagnosis made at other centers.
5. In order to perform accurate prenatal diagnosis, blood samples are required from the affected individual in the family, both parents of the fetus and possibly from other members. We request the submission of both a direct and a cultured fetal specimen (amniotic fluid or CVS) or two sets of primary cultures for each prenatal study. All fetal studies will be performed twice, ideally on direct first and then on culture to confirm. The final report for a fetal analysis will be sent only after the confirmation study is complete.
6. Generally, these tests are relatively new and are being improved and expanded continuously. The tests are not considered research, but are considered to be the best and newest laboratory service which can be offered. This testing is often complex and utilizes specialized materials so that there is always some small possibility that the test will not work properly or that an error will occur. There is a low error rate (perhaps 1 in 1000 samples) even in the laboratories. My signature below acknowledges my voluntary participation in this test, but in no way releases the laboratory and staff from their professional and ethical responsibility to me.
7. I understand that my sample is not being banked. The laboratory does not return DNA samples to individuals or physicians. However, in some cases it may be possible for the laboratory to reanalyze my remaining DNA upon request. The request for additional studies must be ordered by my referring physician/counselor and there will be an additional fee.
- 8a. Once my test result is completed, an aliquot of my DNA may be made anonymous (name and all other identifiers removed) and used for research purposes. Any results obtained could not be related to the original source, so no results would be reported.
- 8b. I indicate my desire to opt out of participation in anonymized research studies using my DNA sample by checking this box:
9. Because of the complexity of DNA based testing and the important implications of the test results, results will be reported to me only through a physician or genetic counselor whom I designate. The result reports are confidential; they will only be released to other medical professionals or other parties with my written consent. All laboratory data is confidential and will not be released within legal limit. Participation in DNA testing is completely voluntary.
10. I will receive a copy of this consent form.

Signature: _____ Witnessed by: _____

Date (mm/dd/yy): ___/___/___

Physician's/Counselor's Statement: I have explained DNA testing to this individual. I have addressed the limitations outlined above, and I have answered this person's questions.

Signature: _____ Date (mm/dd/yy): ___/___/___