NOVALAB
Reference Medical Lab

Hereditary Cancer Panel (CGx) Requisition Form

Patient Information

Last Name: _____ First Name: _____ Age: _____

Sex for Clinical Use: ○ F ○ M ○ Unspecified Date of Birth: ___/___/___ MRN: _____

Patient Address: _____ City: _____

State: _____ Zip: _____ County: _____ Phone: _____

Please Attach Patient Insurance, Patient Medication List, and Demographic Information

Place Barcode Here
(required)

Sample Information

Specimen Type (please check): ○ **Buccal Swab** (OCD-100) ○ **Saliva** (OGD-510) **Collected By:** _____

Collection Date: ____/____/____ **Collection Time:** _____ ○ **AM** ○ **PM**

ICD-10 Codes
(required)

_____

_____

_____

_____

Provider Information

Name of Practice: _____ Ordering Provider: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____ Office Phone #: _____ Fax #: _____

Insurance Information

○ **Self Pay** ○ **Insurance Pay** Insurance Company: _____ Policy ID: _____ Other: _____

Relationship to Policy Holder: ○ **Self** ○ **Spouse/Partner** ○ **Child** ○ **Other:** _____

Policy Holder Information (if not self): First Name: _____ Last Name: _____

Panel Selection

○ **Hereditary Cancer (CGx) Panel**

APC	BAP1	BMPR1A	BRCA2	CDH1	CDKN2A (p14ARF)	CHEK2	EPCAM*	GREM1*	MLH1	MSH6	NF1	PALB2	POLD1*	PTEN	RAD51D	STK11
ATM	BARD1	BRCA1	BRIP1	CDK4*	CDKN2A (p16INK4a)	COL1A1	FBN1	MITF*	MSH2	MUTYH	NBN	PMS2**	POLE*	RAD51C	SMAD4	TP53

Medical History

Personal Medical History

- ○ Breast — Age at Diagnosis: _____
  - ○ Triple negative (ER-, PR-, HER2-) — Age at Diagnosis: _____
  - ○ Multiple primaries — Age at Diagnosis: _____
- ○ Ovarian — Age at Diagnosis: _____
  - ○ Check if non-epithelial
- ○ Prostate (Cleason score >7) — Age at Diagnosis: _____
- ○ Pancreatic — Age at Diagnosis: _____
- ○ Endometrial/Uterine — Age at Diagnosis: _____
- ○ Colon/Rectal — Age at Diagnosis: _____
- ○ Stomach — Age at Diagnosis: _____
- ○ Melanoma — Age at Diagnosis: _____

○ Other Cancer(s): _____

○ ICD-10 Codes: _____

Family Medical History

- ○ Breast — Family Member(s): _____ Age at Diagnosis: _____
  - ○ Triple negative (ER-, PR-, HER2-) — Family Member(s): _____ Age at Diagnosis: _____
  - ○ Multiple primaries — Family Member(s): _____ Age at Diagnosis: _____
- ○ Ovarian — Family Member(s): _____ Age at Diagnosis: _____
  - ○ Check if non-epithelial
- ○ Prostate (Cleason score >7) — Family Member(s): _____ Age at Diagnosis: _____
- ○ Pancreatic — Family Member(s): _____ Age at Diagnosis: _____
- ○ Endometrial/Uterine — Family Member(s): _____ Age at Diagnosis: _____
- ○ Colon/Rectal — Family Member(s): _____ Age at Diagnosis: _____
- ○ Stomach — Family Member(s): _____ Age at Diagnosis: _____
- ○ Melanoma — Family Member(s): _____ Age at Diagnosis: _____

○ Other Cancer(s): _____

○ ICD-10 Codes: _____

Other Personal History

○ Ashkenazi Jewish descent ○ Bone marrow transplant recipient ○ Previous genetic testing for hereditary cancer ○ Current diagnosis of a hematologic cancer

Physician Information

VUS DETAILS *In the event a Variant of Uncertain Significance (VUS) is identified, you and your patient will receive the technical details in the report.*

MEDICAL NECESSITY
Required for Insurance

☐ I attest that this test is medically necessary for the diagnosis or detection of a disease or disorder, and that the results will be used in medical management and care decisions for the patient.

INFORMED CONSENT
Patient Must Consent

☐ I attest that the patient has read the Novalab Corp Informed Consent or had it read to him or her, and that I have fully informed the patient about the purpose, capabilities and limitations of Novalab Corp's Hereditary Cancer Test. The patient has voluntarily given full consent for Novalab Corp's Hereditary Cancer Test, and a signed copy of this consent is available on file. Any Novalab Corp Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

By submitting this Test Requisition Form, I attest that I am the ordering physician or am authorized under applicable laws and regulations to order genetic testing for the patient. If the patient's credit card information has been submitted, I also attest that the patient has authorized me to select the self-pay option and enter his or her payment information on his or her behalf. The patient has authorized **Novalab Corp** and its designees to share the information on this form and related ordering information with his/her insurer for the purpose of processing, receiving payment, and appealing claims on behalf of the patient, and has agreed that any insurance payment sent directly to him/her will be remitted to **Novalab Corp** within 30 days. The patient has also been informed that he/she shall be responsible for any co-pays, deductibles, and co-insurance, and any other amounts not paid by insurance. I agree to **Novalab Corp**'s transfer of the information in this form and the ordering physician's name to a Letter of Medical Necessity as authorization for insurance billing. I further attest that any information entered on this Test Requisition Form, or otherwise provided by me on behalf of the patient, is true and correct to the best of my knowledge, and that the patient has consented to receive communications about his/her genetic test from **Novalab Corp** This genetic test and related services are governed by **Novalab Corp**'s Terms of Service, and information provided on this Test Requisition Form is subject to **Novalab Corp**'s Privacy Policy, both of which are available upon request.

Provider Signature: _____ Date: _____

Provider Name: _____ NPI: _____

Patient Signature: _____ Date: _____