

Hereditary Cancer (Comp) Requisition

Please attach detailed medical records, insurance card front/back, and clinical information to the requisition form.



PRIMARY PATIENT			
LAST NAME		FIRST NAME	
DATE OF BIRTH (MM/DD/YYYY)		GENETIC SEX Male Female Unknown	
MED REC#/PATIENT IDENTIFIER		ETHNICITY	
ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PHONE		EMAIL	
SAMPLE DRAW DATE (MM/DD/YYYY)	SAMPLE TYPE Blood Bucal Other Extracted DNA & DNA Source: (Blood, Bucal, Tissue, Fibroblast)		

I have read the Informed Consent document and I give permission to Tesis Labs to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at Tesis Labs and for publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications. More information is available at www.tesislabs.com

Opt out of research

Check this box if you are a New York state resident and give permission for Tesis Labs to retain any remaining sample longer than 60 days after the completion of testing.

PATIENT SIGNATURE (REQUIRED FOR BILLING PURPOSES) X	DATE (MM/DD/YYYY)
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ORDER PROVIDER			
INSTITUTION/PRACTICE NAME		INSTITUTION PHONE/FAX/EMAIL	
PROVIDER LAST NAME		PROVIDER FIRST NAME	
NPI (USA)	MINC (CANADA)	PROVIDER TITLE (MD, DO, GC)	
PROVIDER ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PROVIDER PHONE		FAX REPORT TO	
GC/PRIMARY CONTACT		GC/PRIMARY CONTACT PHONE/EMAIL/FAX	

I attest that the patient has received and read the Tesis Labs Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any Tesis Labs Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

STATEMENT OF MEDICAL NECESSITY

By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

ORDERING PROVIDER SIGNATURE (REQUIRED) X	DATE (MM/DD/YYYY)
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TEST REQUESTED	
TEST NAME (see Page 3 for list of genes/panels)	INDICATIONS FOR TESTING Check all that apply: Diagnostic Presymptomatic Family History Family Variant Other
+ADD/-MINUS GENES	CLINICAL/SUSPECTED DIAGNOSIS: Please attach medical records or complete Page 2.

INSURANCE BILLING				Attach front and back of all insurance cards, ABN, medical criteria form			
PLEASE ATTACH INSURANCE CARDS FOR BILLING		ICD-10 VALID CODE		REFERRAL/PRIOR AUTH		By signing above, the patient or insured authorizes Tesis Labs to release medical information concerning the test to the assigned insurance company.	
PRIMARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #			
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)			
SECONDARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #			
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)			

INSTITUTIONAL BILLING			
INSTITUTION/PRACTICE NAME			
ATTENTION TO			
ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PHONE	FAX/EMAIL		

SELF PAY			
Use patient information above for billing		By signing above, the patient or payor authorizes Tesis Labs to contact them directly, and use the provided billing instructions to bill the indicated method.	
Use information below for billing			
PAYOR LAST NAME		PAYOR FIRST NAME	
ADDRESS			
CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY
PHONE	FAX/EMAIL		

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CLINICAL DETAILS <small>(Check all that apply)</small>					
No Personal History Cancer					
Cancer/Tumor Type	Onset Age		Cancer/Tumor Type	Onset Age	Pathology and Other Info
Brain			Melanoma		
Breast		ER: POS (+) NEG (-) UNK (?) PR: POS (+) NEG (-) UNK (?) HER2/neu: POS (+) NEG (-) UNK (?)	Ovarian		Serous
2nd Primary Breast		ER: POS (+) NEG (-) UNK (?) PR: POS (+) NEG (-) UNK (?) HER2/neu: POS (+) NEG (-) UNK (?)	Fallopian Tube		Mucinous
Colorectal		Location: _____	Primary Peritoneal		Endometrioid
Hematologic*			Pancreatic		Clear cell
GI Polyps		Adenomatous	Prostate		Borderline / LMP
		Other: _____	Uterine		Other: _____
		Number of Polyp(s)#: _____	Other Cancer		
Other Clinical History:					
PREVIOUS OR CURRENT TREATMENT					
Allogeneic bone marrow or peripheral stem cell transplant*		Chemotherapy*		Radiation	
Surgery, Specify: _____					
*DNA analysis from blood samples of individuals who have undergone stem cell transplants, bone marrow transplants, or chemotherapy may not reect the germline genotype. Similarly, DNA analysis from blood samples of individuals with hematologic malignancy may not distinguish between somatic and germline variants.					
CLINICAL TESTING RESULTS <small>Attach relevant reports</small>			TUMOR TESTING RESULTS <small>Attach relevant reports</small>		
Germline testing results: _____			Microsatellite instability (MSI) results: _____		
Somatic testing results: _____			Immunohistochemistry (IHC) results: _____		
			Other, specify: _____		
FAMILY HISTORY <small>Attach pedigree and additional pages as needed</small>					
FAMILY MEMBER 1 NAME		RELATION TO PATIENT	GENETIC SEX Male Female Unknown		
DIAGNOSIS AND/OR SYMPTOMS			AGE OF ONSET	DOB (MM/DD/YYYY)	
FAMILY MEMBER 2 NAME		RELATION TO PATIENT	GENETIC SEX Male Female Unknown		
DIAGNOSIS AND/OR SYMPTOMS			AGE OF ONSET	DOB (MM/DD/YYYY)	
FAMILY MEMBER 3 NAME		RELATION TO PATIENT	GENETIC SEX Male Female Unknown		
DIAGNOSIS AND/OR SYMPTOMS			AGE OF ONSET	DOB (MM/DD/YYYY)	

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INSTRUCTIONS

1. Complete the patient and provider information section.
2. Read and sign the informed consent policy statement. The complete patient informed consent form for genetic testing can be found on tesislabs.com. Signature from the provider on Page 1 of the TRF is required for all testing. Signature from the patient is only required for billing purposes.
3. Write in the test name on Page 1 or select the gene(s)/panel(s) below.
4. Indicate any relevant test options on Page 1.
5. Please visit tesislabs.com for specimen requirements.
Extracted DNA must be extracted from a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by CAP and/or CMS.

REQUIRED FOR INSURANCE CHECKLIST

- Detailed medical record (pedigree if available)
- ICD-10 codes(s)
- Physician, patient, and insured signatures
- Copy of insurance card(s) - front/back
- Insurer specific forms (i.e. ABN)
- Insurance authorization, if available
- For Medicare, Medicare criteria form is required

For the most updated information and limitations on our products and services, please visit tesislabs.com

SELEC PANEL – Select only one test

Comprehensive Cancer <small>Select all available genes.</small>	Colorectal Comprehensive	Nervous System / Brain Comprehensive	Prostate Comprehensive
Breast Cancer STAT (7-10 day TAT) ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, STK11, TP53	APC, AXIN2, BMPR1A, CDH1, CHEK2, EPCAM, FAN1, GALNT12, GREM1, MLH1, MLH3, MSH2, MSH6, MUTYH, NTHL1, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53	ALK, APC, ATM, DICER1, EPCAM, HRAS, LZTR1, MEN1, MLH1, MSH2, MSH6, NF1, NF2, PHOX2B, PMS2, PRKAR1A, PTCH1, PTEN, POT1, SMARCA4, SMARCB1, SMARCE1, SUFU, TP53, TSC1, TSC2, VHL	ATM, BRCA1, BRCA2, CHEK2, EPCAM, HOXB13, MLH1, MSH2, MSH6, NBN, PMS2, TP53
Breast Comprehensive ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, MLH1, MRE11, MSH2, NBN, NF1, PALB2, PTEN, RAD50, RAD51C, RAD51D, STK11, TP53, XRCC2	Endometrial Comprehensive BRCA1, BRCA2, EPCAM, MLH1, MSH2, MSH6, PMS2, POLD1, PTEN, TP53	Ovarian Comprehensive BARD1, BRCA1, BRCA2, BRIP1, CDH1, EPCAM, MLH1, MRE11, MSH2, MSH6, NBN, PALB2, PMS2, RAD51C, RAD51D, SMARCA4, STK11, TP53	Renal / Urinary Comprehensive BAP1, CDC73, CDKN1C, DICER1, DIS3L2, EPCAM, FH, FLCN, GPC3, MET, MITE, MLH1, MSH2, MSH6, PMS2, PTEN, SDHA, SDHB, SDHC, SDHD, SMARCA4, SMARCB1, TP53, TSC1, TSC2, VHL, WT1
Breast and Ovarian Comprehensive ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, MLH1, MRE11, MSH2, NBN, NF1, PALB2, PTEN, RAD50, RAD51C, RAD51D, STK11, TP53, XRCC2	Gastric Comprehensive APC, BMPR1A, CDH1, CTNNA1, EPCAM, KIT, MLH1, MSH2, MSH6, NF1, PDGFRA, PMS2, SMAD4, STK11, TP53	Pancreatic Comprehensive APC, ATM, BMPR1A, BRCA1, BRCA2, CDK4, CDKN2A, EPCAM, FANCC, MEN1, MLH1, MSH2, MSH6, NF1, PALB2, PMS2, SMAD4, STK11, TP53, TSC1, TSC2, VHL	Sarcoma Comprehensive APC, BLM, CDKN1C, DICER1, EPCAM, FH, HRAS, KIT, MLH1, MSH2, MSH6, NBN, NF1, PDGFRA, PMS2, PRKAR1A, PTCH1, RB1, RECQL4, SDHA, SDHB, SDHC, SDHD, SUFU, TP53, WRN
	Hematologic Malignancy Comprehensive ATM, BLM, CEBPA, EPCAM, GATA2, HRAS, MLH1, MSH2, MSH6, NBN, NF1, PMS2, RUNX1, TERC, TERT, TP53	Paraganglioma-Pheochromocytoma Comprehensive FH, MAX, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL	Thyroid Comprehensive APC, CHEK2, DICER1, PRKAR1A, PTEN, RET, TP53
	Melanoma Comprehensive BAP1, BRCA2, CDK4, CDKN2A, CHEK2, MC1R, MITE, POT1, PTEN, RB1, SLC45A2, TP53, TYR		Custom Select genes below to create a custom panel.

If I am covered by insurance, I authorize Tesis Labs and their contracted billing company to give my insurance carrier the information on this form and provided by my healthcare provider that is necessary for reimbursement. I understand that I am responsible for deductible and coinsurance amounts as indicated by my insurance carrier. I agree to assist in resolving insurance claim issues and if I do not assist, I may be responsible for the full cost of the test. I understand that I am responsible for sending Tesis Labs any and all of the money that I receive directly from my insurance carrier in payment for this test.

If the test is not authorized by or is not covered by my insurance, then I will be contacted with the option to either cancel the ordered test or elect to pay out-of-pocket according to the proposed payment plan provided to me when I am contacted. If I elect to pay out-of-pocket, I will be responsible for all payment obligations arising from the ordered testing and guarantee payment for these services. I understand that if payments or arrangements are not made after 3 statements my information may be sent to collections.

Tesis Labs is committed to support you with your share of costs. If required, you will be contacted by our team to setup a payment plan for your portion of the costs using the following forms of payment: Check, Visa, Master Card. You may also contact our billing team at 720-726-2130

PATIENT SIGNATURE (REQUIRED FOR BILLING PURPOSES) X	DATE (MM/DD/YYYY)
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RE-REQUISITION INSTRUCTIONS

Re-requisition for additional genetic testing is at no additional charge within 90 days of the original report release date. Any re-requisitioned test must be ordered from the same cancer category of tests. If you would like the results from the first test included in the next report, please also select the original test panels and genes.

1. Indicate which panels and genes you would like tested on this page.
2. Fill in the identifiers to the right based on the previous report.
3. If provider information and patient clinical information has not changed, only this third page is required for re-requisition.
4. If the provider information has changed, the first page is required.
5. If the patient's clinical information has changed, the second page is required.

LAST NAME	FRIST NAME
DATE OF BIRTH (MM/DD/YYYY)	MED REC#/PATIENT IDENTIFIER