


CANCER REQUISITION FORM

PATIENT INFORMATION:						
Patient Name: (Last, First)		Date of Birth	Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Unknown <input type="checkbox"/>
Phone:	Address:		City	State	Zip	

REFERRING PHYSICIAN:			
Physician:	NPI:	Phone:	Fax:
Address:		City	State Zip
 Signature:		Date:	

ADDITIONAL REPORT RECIPIENTS:			
Physician:	NPI:	Phone:	Fax:

SAMPLE INFORMATION:		Sample Type (Please Select One):
Date of Collection:		<input type="checkbox"/> Peripheral Blood
Hospital:		<input type="checkbox"/> Bone Marrow
Accession #:		<input type="checkbox"/> Saliva
		<input type="checkbox"/> Buccal
		<input type="checkbox"/> Other: _____

PATIENT CLINICAL HISTORY / INDICATION FOR STUDY (Please attach pathology reports if possible):					
Ancestry (Select all that apply):					
<input type="checkbox"/>	White/ Non-Hispanic	<input type="checkbox"/>	Ashkenazi Jewish	<input type="checkbox"/>	Pacific Islander
<input type="checkbox"/>	Hispanic / Latino	<input type="checkbox"/>	Asian	<input type="checkbox"/>	Middle Eastern
<input type="checkbox"/>	Black / African	<input type="checkbox"/>	Native American	<input type="checkbox"/>	Other: _____

REASON FOR TESTING						
ICD-10				Add ICD-10 codes pertaining to the patient's diagnosis/ reason for test		

PATIENT TESTING HISTORY	
<input type="checkbox"/>	No Previous Molecular/ Genetic Testing
<input type="checkbox"/>	Germline genetic testing Test performed: _____
<input type="checkbox"/>	Somatic genetic testing Test performed: _____

OTHER COMMENTS:

Please attach or fax any previous test results if applicable

HISTORY OF CANCER:
Personal History of Cancer

No Personal History of Cancer			
Diagnosis		Age at Diagnosis	Pathology and other Information
Breast Cancer	Left <input type="checkbox"/> Right <input type="checkbox"/>		<input type="checkbox"/> Ductal Invasive <input type="checkbox"/> Lobular Invasive <input type="checkbox"/> DCIS <input type="checkbox"/> Bilateral <input type="checkbox"/> Premenopausal <input type="checkbox"/> Triple Negative (ER-, PR-, HER2-)
Endometrial/Uterine Cancer			
Ovarian Cancer			<input type="checkbox"/> Fallopian tube <input type="checkbox"/> Primary peritoneal
Prostate Cancer			Gleason score: _____
Colon/Rectal Cancer			<input type="checkbox"/> Mucinous <input type="checkbox"/> Signet Ring <input type="checkbox"/> Medullary Growth Pattern <input type="checkbox"/> Tumor Infiltrating lymphocytes <input type="checkbox"/> Crohn's Like Lymphocytic Reaction
GI Polyps			<input type="checkbox"/> Adenomatous Polyp # _____ <input type="checkbox"/> Other Polyp Polyp # _____
Hematologic Cancer			Type: _____ Allogenic bone marrow or peripheral stem cell transplant
Other: _____			

Family History of Cancer:

No Known Family History of Cancer			Limited Family Structure (Limited family history or fewer than 2 1st or 2nd degree relatives lived beyond age 45)	
Relationship to Patient:	Maternal	Paternal	Cancer Site or Polyp Type	Age at Diagnosis
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

Please provide as much information to ensure the patient receives proper medical management recommendations and proper reimbursement.

Instructions: For each gene selected, please fill the checkbox for the test to be performed. For example, if requesting PTEN deletion and duplication testing only the column labeled "del/dup" should be filled. Avoid filling two check boxes for the same gene. If both sequencing and deletion duplication are requested, only fill the check box labeled "seq+del/dup" this will indicate both tests are to be performed for the single gene selected. Some genes may not allow for certain tests to be performed in which case no check box will be available. All panel tests will include both sequencing and deletion duplication analysis.

MOLECULAR TESTING

SINGLE SITE ANALYSIS

Gene Name:	Mutation:	GC Lab number (or lab where tested)
Name of Proband:		Relationship to relative:
Positive control sample: <input type="checkbox"/> Sample Provided <input type="checkbox"/> Results Provided		
Note: If targeted mutation analysis, please contact lab for positive control collection kit and attach test results		

MULTI-GENE PANELS: Panels Include Sequence Analysis and Del/Dup

<input type="checkbox"/>	Ashkenazi BRCA Jewish Panel	185delAG, 5385insC, and 6174delT
<input type="checkbox"/>	BRCA Panel	BRCA1, BRCA2
<input type="checkbox"/>	Comprehensive Breast Panel	ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, NBN, PALB2, PTEN, RAD51C, STK11, TP53
<input type="checkbox"/>	Comprehensive Ovarian Panel	ATM, BRCA1, BRCA2, BRIP1, CHEK2, MUTYH, MLH1, MSH2, MSH6, PALB2, PMS2, RAD51C, STK11, TP53, EPCAM (del/dup only)
<input type="checkbox"/>	Core Breast Panel	BRCA1, BRCA2, CDH1, PTEN, TP53, STK11
<input type="checkbox"/>	Colon Cancer Panel	APC, BMPR1A, MLH1, MSH2, MSH6, MUTYH, PTEN, PMS2, SMAD4, STK11, TP53, EPCAM (del/dup only)
<input type="checkbox"/>	Juvenile Polyposis Syndrome	BMPR1A, SMAD4
<input type="checkbox"/>	Lynch Syndrome Panel	MLH1, MSH2, MSH6, MUTYH, PMS2, EPCAM (del/dup only)
<input type="checkbox"/>	Pancreatic Cancer Panel	ATM, BRCA1, BRCA2, CDKN2A, MLH1, MSH2, MSH6, MUTYH, PMS2, EPCAM, PALB2, TP53, STK11
<input type="checkbox"/>	Polyposis Syndrome Panel	FAP, Gardner syndrome, Turcot syndrome, attenuated FAP and MUTYH-associated polyptosis (MAP)
<input type="checkbox"/>	Prostate Cancer Panel	BRCA1, BRCA2, NBN, TP53, CHEK2, MLH1, MSH2, PMS1, PMS2, EPCAM, ATM, PALB2
<input type="checkbox"/>	Tuberous Sclerosis	TSC1, TSC2

SINGLE GENE DISORDERS

Seq+Del/Dup	Seq	Del/Dup	Gene	Disorder
Hereditary Brain Tumors				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NF1	Neurofibromatosis, Type 1
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NF2	Neurofibromatosis, Type 2
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SMARCB1	Schwannomatosis
Hereditary Breast Cancer				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ATM	Breast cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BRCA1	Hereditary breast and ovarian cancer (HBOC)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BRCA2	Hereditary breast and ovarian cancer (HBOC)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CHEK2	CHEK2-Related Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PALB2	PALB2-Related Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PTEN	Hamartoma Tumor syndrome, Cowden syndrome & Bannayan-Riley-Ruvalcaba syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TP53	Li-Fraumeni syndrome
Gastrointestinal Cancer				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	APC	Familial Adenomatous Polyposis/ Attenuated familial adenomatous polyposis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CDH1	Familial Cutaneous Malignant Melanoma/ Hereditary Diffuse Gastric Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MUTYH	MUTYH-associated polyposis (MAP)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SMAD4	Juvenile polyposis syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STK11	Peutz-Jeghers syndrome
Genitourinary Cancer				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FLCN	Birt-Hogg-Dube syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FH	Hereditary Leiomyomatosis and Renal Cell Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VHL	Von Hippel-Lindau syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WT1	Wilms Tumor; Denys-Drash syndrome

SINGLE GENE DISORDERS

Seq+Del/Dup	Seq	Del/Dup	Gene	Disorder
Endocrine Tumors				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MEN1	Multiple Endocrine Neoplasia, Type 1 (MEN1)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RET	Familial Medullary Thyroid Carcinoma, Multiple Endocrine Neoplasia Types 2A&2B MEN2
Other Hereditary Cancer				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ATM	Ataxia telangiectasia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BLM	Bloom syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FLCN	Birt-Hogg-Dube syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	JAK2 V617F	JAK2-related myeloproliferative disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RB1	Retinoblastoma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NBN	Nijmegen Breakage syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NSD1	Sotos syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PTCH1	Nevoid Basal Cell Carcinoma syndrome (Gorlin syndrome)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SBDS	Shwachman-Diamond syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WRN	Werner syndrome

Custom Panel (Please specify gene and testing type):

If there is a panel that is not on our list, please fill out the genes that are to be tested and the test to be performed.

Gene: _____	Gene: _____	Gene: _____
Test: _____	Test: _____	Test: _____

SHIPPING INSTRUCTIONS:

Ship to:

Genetics Center
 North Door, Suite AA
 211 S. Main St.
 Orange, CA 92686

