Medical College of Wisconsin | Genomic Sciences & Precision Medicine Center

Phone 414.955.2550

Hereditary Cancer Panels Requisition

Client Information

Required Information

Account #: ________________ **Account Name:** ________________________________

Street Address: ____

____

City, ST, ZIP: ____

Phone: ____________________ **Fax:** ____________________

Requisition Completed by: ______________________________ Date: __________

Ordering Physician (please print: Last, First): ______________________ NPI #: __________

Treating Physician (please print: Last, First): ______________________

The undersigned certifies that he/she is licensed to order the test(s) listed below and that such test(s) are medically necessary for the care/treatment of this patient.

Authorized Signature: ______________________________ Date: __________

Billing Information

Required: Please include face sheet and front/back of patient's insurance card.

Specimen Origin (Must Choose 1): ☐ Hospital Patient (in) ☐ Hospital Patient (out) ☐ Non-Hospital Patient

Bill to: ☐ Client Bill ☐ Insurance ☐ Medicare ☐ Medicaid ☐ Patient/Self-Pay

☐ Split Billing - Client (TC) and Insurance (PC) ☐ OP Molecular to MCR, all other testing to Client

☐ Bill charges to other Hospital/Facility: ______________________

Prior Authorization #______________________

Clinical Information

Required: Please attach patient's pathology report, clinical history, and other applicable report(s).

☐ **Diagnosis Code/ICD Code (Required):** ______________________

Reason for Referral: ______________________

Patient Information

Last Name: ____

First Name: ______________________ **M.I.** ________ ☐ **Male** ☐ **Female**

Date of Birth: mm _______ / dd _______ / yyyy ___________ Medical Record #: ______________

Client represents it has obtained informed consent from patient to perform the services described herein.

Reason for Referral:

☐ Patient History of Cancer ☐ Family History of Cancer ☐ Known Familial mutation

☐ Other: ____

Specimen Information

Specimen ID: ______________________ **Block ID:** ______________________

Collection Date: mm _______ / dd _______ / yyyy _________ **Collection Time:** _______ ☐ AM ☐ PM

Retrieved Date: mm _______ / dd _______ / yyyy _________

Hospital Discharge Date: mm_______ / dd_______ / yyyy _________

☐ Peripheral Blood: Green Top(s) _______ Purple Top(s) _______ Other ______________

Comments

Patient Clinical Data

Race/Ethnicity - Please check all that apply

☐ African American/Black

☐ Hispanic

☐ Eastern/Central European

☐ Asian

☐ Jewish (Ashkenazi)

☐ Western/Northern European

☐ Middle Eastern

☐ Native American

☐ Other: ____

Patient history of cancer - Check sites and fill in age of diagnosis

☐ Breast

☐ Right ____________ ☐ Left ______________

☐ Other (explain): ______________________________

☐ Colorectal

☐ Right Colon ____________ ☐ Left Colon ___________

☐ Transverse Colon _________ ☐ Rectum ____________

☐ Other (explain): ______________________________

☐ Other Cancer (explain): ______________________________

☐ Mismatch Repair (MMR) IHC Results: ______________________________

Family history of cancer - Relationship, sites

____

____

Has the patient ever had a BRCA1/2 test before? ☐ Yes ☐ No

Note: If done previously, a patient will likely be responsible for full payment.

Hereditary Cancer Tests

☐ **BRCA1/2 Mutation and Del/Dup Analysis:** Includes detection of point mutations, deletions, duplications, and rearrangements in the BRCA1 and BRCA2 genes

☐ **BRCA1 Mutation and Del/Dup Analysis:** Includes detection of point mutations, deletions, duplications, and rearrangements

☐ **BRCA2 Mutation and Del/Dup Analysis:** Includes detection of point mutations, deletions, duplications, and rearrangements

☐ **EGFR T790M Germline Mutation Analysis**

☐ **Hereditary Cancer Comprehensive Panel:** Includes detection of point mutations, small insertions/deletions in 73 genes (see back for test details)

☐ **Hereditary Cancer Susceptibility for Pediatrics:** Includes detection of point mutations, small insertions/deletions in 21 genes (see back for test details)

☐ **Hereditary DNA Repair Panel for Prostate Cancer:** Includes detection of point mutations, small insertions/deletions in 20 genes (see back for test details)

☐ **HOXB13 Genotyping***

☐ **Inherited Bone Marrow Failure Panel:** Includes detection of point mutations, small insertions/deletions in 58 genes (see back for test details)

☐ **Lynch Syndrome:** Includes detection of point mutations, deletions, duplications, and rearrangements in the EPCAM, MLH1, MSH2, MSH6, and PMS2 genes

☐ **EPCAM Mutation and Del/Dup Analysis:** Includes detection of point mutations, deletions, duplications, and rearrangements

☐ **MLH1 Mutation and Del/Dup Analysis:** Includes detection of point mutations, deletions, duplications, and rearrangements

☐ **MSH2 Mutation and Del/Dup Analysis:** Includes detection of point mutations, deletions, duplications, and rearrangements

☐ **MSH6 Mutation and Del/Dup Analysis:** Includes detection of point mutations, deletions, duplications, and rearrangements

☐ **PMS2 Mutation and Del/Dup Analysis**: Includes detection of point mutations, deletions, duplications, and rearrangements

Informed Consent REQUIRED

A signed GSPMC Consent Form for Hereditary Cancer Testing is required.

Testing may be delayed until signed consent is received.

*Tests with asterisk do not have reimbursement history. Patient may be responsible for full cost of test if coverage is denied.

Specimen Requirements

Refrigerate specimen if not shipping immediately and use cool pack during transport. Please call Client Services Team with any questions regarding specimen requirements or shipping instructions at 414.955.2550.

Additional Billing Information

Any organization referring specimens for testing services pursuant to this Requisition Form ("Client") expressly agrees to the following terms and conditions.

1. **Binding Service Order.** This Requisition Form is a legally binding order for the services ordered hereunder ("Services") and Client agrees that it is financially responsible for all tests billable to Client hereunder.
2. **Third Party Billing by GSPMC and Right to Bill Client.** Client agrees to accurately indicate on the front of the Requisition Form that either Client should be billed (e.g., Client receives reimbursement pursuant to a non-fee-for-service basis, including, but not limited to, a capitated, diagnostic related group ("DRG"), per diem, all-inclusive, or other such bundled or consolidated billing arrangement) or GSPMC should bill the applicable federal, state or commercial health insurer or other third party payer (collectively, "Payers") for all Services ordered pursuant to this Requisition Form. For all such Services billable to Payers, Client agrees to provide all billing information necessary for GSPMC to bill such payer. In the event GSPMC: (i) does not receive the billing information required for it to bill any Payers within ten days of the date that any Services are reported by GSPMC; (ii) the Services were performed for patients who have no Payer coverage arrangements; or (iii) the Payer identified by Client denies financial responsibility for the Services and indicates that Client is financially responsible, GSPMC shall have the right to bill such Services to Client.

Test Descriptions

Please see complete test descriptions and all available tests at our website.

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