TEST REQUISITION FORM

Hereditary Cancer

LINCOLN Reference Laboratory

P +1.800.366.3773 | F +1.908.845.0253 | info@LincolnReference.com

Highlighted fields are required information*

PATIENT INFORMATION

LAST NAME* | FIRST NAME*

SEX ASSIGNED AT BIRTH* ○ Male ○ Female ○ Unknown | DATE OF BIRTH (MM/DD/YYYY)*

MRN | ETHNICITY

ADDRESS

CITY | STATE | POSTAL CODE | COUNTRY

PHONE | EMAIL

SAMPLE TYPE

○ Blood ○ Buccal/Saliva ○ Other: _____

○ Extracted DNA & DNA Source (Blood, Buccal, Tissue, Fibroblast): _____

SAMPLE DRAW DATE (MM/DD/YYYY)*

PATIENT ACKNOWLEDGEMENT

I have read the Informed Consent document and I give permission to Lincoln Reference Lab and its entities to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at Lincoln Reference Lab 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.lincolnreference.com

☐ Check this box if you are a New York state resident and give permission for Lincoln Reference Lab to retain any remaining sample longer than 60 days after sample collection.

☐ Opt out of research

X _____ Patient Signature (Required for billing purposes)* | Date (MM/DD/YYYY)

ORDERING PROVIDER

INSTITUTION/PRACTICE NAME

INSTITUTION PHONE / FAX | INSTITUTION EMAIL

ORDERING PROVIDER(S)

NPI (USA)/MINC (Canada) | PROVIDER TITLE (MD, DO, GC)

PROVIDER ADDRESS

CITY | STATE | POSTAL CODE | COUNTRY

PROVIDER PHONE | FAX/EMAIL REPORT TO

STATEMENT OF INFORMED CONSENT

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.

I attest that the patient has received and read the Lincoln Reference Lab Informed Consent document, or has had it read to them, 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 Lincoln Reference Lab Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

X _____ Ordering Provider Signature (Required)* | Date (MM/DD/YYYY)

PATIENT COMMUNICATION CONSENT

☐ By checking this box, you acknowledge and agree that:

a. By executing this agreement, you are providing express written consent for Lincoln Reference Lab, their affiliates and subsidiaries, and parties making contact on their behalf to call and text you using automatic telephone dialing systems and artificial or pre-recorded messages at the telephone number you have provided, about your out-of-pocket estimation, even if your telephone number is currently listed on any state, federal, local or corporate Do Not Call list.

b. Your Consent to be contacted through the use of automatic telephone dialing systems and artificial or pre-recorded messages is not required in order to purchase any property, goods, or services. If you would like to speak with our Benefits Investigation team, you can reach them at 1-800-366-3773

SELECT TEST PANEL

Please select only one test panel

All genes included on the cancer-specific panels are included on the full comprehensive panel. If multiple panels are selected, we will combine them into a single Custom Cancer Panel.

For the most up to date panel information and genes included please visit LincolnReference.com.

PAN-CANCER

- ○ **Full Comprehensive Panel** (FT-TP00048) Includes all subpanels listed
- ○ **Full Focus Panel** (FT-TP00105)

BREAST & OVARIAN CANCERS

- ○ **BRCA1 & BRCA2 Focus Panel** (FT-TP01125)
- ○ **Breast & Ovarian Cancer Focus Panel** (FT-TP00462)
- ○ **Breast Cancer STAT Panel** (FT-TP01030) (TAT: 10 DAYS)
- ○ **Breast Cancer Comprehensive Panel** (FT-TP00043)
- ○ **Breast Cancer Focus Panel** (FT-TP00101)
- ○ **Ovarian Cancer Comprehensive Panel** (FT-TP00053)
- ○ **Ovarian Cancer Focus Panel** (FT-TP00106)
- ○ **Breast & Ovarian Comprehensive Panel** (FT-TP00461)

ENDOCRINE CANCERS

- ○ **Multiple Endocrine Neoplasia Comprehensive Panel** (FT-TP00182)
- ○ **Paraganglioma-Pheochromocytoma Comprehensive Panel** (FT-TP00055)
- ○ **Thyroid Cancer Comprehensive Panel** (FT-TP00059)

COLORECTAL CANCERS

- ○ **Lynch Syndrome Focus Panel** (FT-TP01543)
- ○ **Colorectal Comprehensive Panel** (FT-TP00044)
- ○ **Colorectal Focus Panel** (FT-TP00102)
- ○ **Polyposis Comprehensive Panel** (FT-TP01535)
- ○ **Adenomatous Polyposis Focus Panel** (FT-TP01534)

OTHERS

- ○ **Endometrial Cancer Comprehensive Panel** (FT-TP00046)
- ○ **Pancreatic Cancer Comprehensive Panel** (FT-TP00054)
- ○ **Gastric Cancer Comprehensive Panel** (FT-TP00049)
- ○ **Prostate Cancer Focus Panel** (FT-TP00107)
- ○ **Hematologic Malignancy Comprehensive Panel** (FT-TP00050)
- ○ **Prostate Cancer Comprehensive Panel** (FT-TP00056)
- ○ **Melanoma Comprehensive Panel** (FT-TP00051)
- ○ **Renal/Urinary Cancer Comprehensive Panel** (FT-TP00057)
- ○ **Nervous System/Brain Comprehensive Panel** (FT-TP00052)
- ○ **Sarcoma Comprehensive Panel** (FT-TP00058)

SINGLE GENE OR KNOWN MUTATION & ADDITIONAL REQUESTS

- ○ **Custom Cancer Panel** (FT-TP00045) Please list gene(s) below.

TEST OPTION

- ○ **Exclude VUS**
- ○ **Add RISE**

Additional specimen required, please submit with proband to reduce delays.

Sample submitted with proband?

○ Yes ○ No

Additional Comments:

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BILLING OPTIONS

Please select a billing option and complete the relevant fields below: ○ Insurance ○ Institution ○ Self-Pay

By signing above, the patient or payor authorizes Lincoln Reference Lab and its entities to contact them directly (including via text), and authorizes Lincoln Reference Lab and its entities to release medical information concerning the test to the assigned insurance company.

INSURANCE/BILLING INFORMATION

Please attach front and back of all insurance cards, ABN, medical criteria form

ICD-10 VALID CODE*	REFERRAL/PRIOR AUTH	Lincoln BENEFITS ID #

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

○ Use institution information above for billing
○ Use information below for billing

INSTITUTION/PRACTICE NAME	ATTENTION TO

ADDRESS

CITY	STATE	POSTAL CODE	COUNTRY

PHONE	EMAIL

SELF-PAY

○ Use patient information above for billing
○ Use information below for billing

By signing above, the patient or payor authorizes Lincoln Reference Lab and its entities to contact them directly, and use the provided billing instructions to bill the indicated method.

PAYOR LAST NAME	PAYOR FIRST NAME

ADDRESS

CITY	STATE	POSTAL CODE	COUNTRY

PHONE	EMAIL

PATIENT CLINICAL HISTORY

Check all that apply

☐ No personal history of cancer

INDICATIONS FOR TESTING Check all that apply

☐ Diagnostic ☐ Family History ☐ Family Variant ☐ Presymptomatic ☐ Other: _____

CANCER/TUMOR TYPE	AGE OF ONSET	PATHOLOGY AND OTHER INFO
☐ Brain		
☐ Breast		ER: ○ POS(+) ○ NEG(-) ○ UNK(?) PR: ○ POS(+) ○ NEG(-) ○ UNK(?) HER2/neu: ○ POS(+) ○ NEG(-) ○ UNK(?)
☐ 2nd Primary Breast		ER: ○ POS(+) ○ NEG(-) ○ UNK(?) PR: ○ POS(+) ○ NEG(-) ○ UNK(?) HER2/neu: ○ POS(+) ○ NEG(-) ○ UNK(?)
☐ Colorectal		Location:
☐ Hematologic		
☐ GI Polyps		☐ Adenomatous: _____ ☐ Other: Number of polyp(s): _____

CANCER/TUMOR TYPE	AGE OF ONSET	PATHOLOGY AND OTHER INFO
☐ Melanoma		
☐ Ovarian ☐ Fallopian tube ☐ Primary peritoneal		ER: ○ POS(+) ○ NEG(-) ○ UNK(?) PR: ○ POS(+) ○ NEG(-) ○ UNK(?) HER2/neu: ○ POS(+) ○ NEG(-) ○ UNK(?)
☐ Pancreatic		ER: ○ POS(+) ○ NEG(-) ○ UNK(?) PR: ○ POS(+) ○ NEG(-) ○ UNK(?) HER2/neu: ○ POS(+) ○ NEG(-) ○ UNK(?)
☐ Prostate		Gleason score: _____ Metastatic: ○ Yes ○ No
☐ Uterine		
☐ Other Cancer		

CLINICAL HISTORY/SUSPECTED DIAGNOSIS

Please attach copy of recent CBC, copy of doctor's notes/clinical history, pathology reports, and any relevant test results.*

PATIENT TESTING HISTORY

Please attach relevant reports

GERMLINE TESTING RESULTS:	MICROSATELLITE INSTABILITY (MSI) RESULTS:	IMMUNOHISTOCHEMISTRY (IHC) RESULTS:

SOMATIC TESTING/TUMOR PROFILE RESULTS:	OTHER, SPECIFY:

FAMILY HISTORY

Attach pedigree and additional pages as needed

FAMILY MEMBER NAME (1)	RELATION TO PATIENT	SEX ASSIGNED AT BIRTH
		○ Male ○ Female ○ Unknown

DIAGNOSIS AND/OR SYMPTOMS	AGE OF ONSET	DATE OF BIRTH (MM/DD/YYYY)

FAMILY MEMBER NAME (2)	RELATION TO PATIENT	SEX ASSIGNED AT BIRTH
		○ Male ○ Female ○ Unknown

DIAGNOSIS AND/OR SYMPTOMS	AGE OF ONSET	DATE OF BIRTH (MM/DD/YYYY)

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INSTRUCTIONS

1. Complete the patient and provider information section.
2. Read and sign the consent statement. If needed, Patient Informed Consent forms for genetic testing can be found on LincolnReference.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. Indicate the test name and any relevant test options on Page 1 of this form.
4. Please visit LincolnReference.com for specimen requirements.
   - Extracted DNA must be collected 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 code(s)
- ☐ Physician, patient, and insured signatures
- ☐ Copy of insurance card(s) - front/back
- ☐ Insurer specific forms (eg. ABN)
- ☐ Insurance authorization, if available
- ☐ For Medicare, a Medicare criteria form is required

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

