GeneType for Colorectal Cancer

Test Requisition Form

Specimen Collection Date: DD / MMM / YYYY

Patient Information

Last Name

First Name

Date of Birth DD / MMM / YYYY

MRN

Address

City

State

Zip code

Phone

I understand that I will be responsible for the amount of $249 related to the services provided to me by GeneType. I understand that the charges presented to me are due in full within 30 days of service. I also understand that this charge is an elective service and only administered by a licensed healthcare provider. I certify that I have agreed to the forgoing, and I am the patient, the patient's representative or duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient Signature

Date DD / MMM / YYYY

Diagnosis (ICD-10) Code:

Ordering Healthcare Provider Information

Last Name

First Name

Practice/Institution Name

Office Contact

Address

City

State

Zip code

NPI Number

Phone

Fax

Email

Your signature constitutes a certification of Medical Necessity and implies consent for genetic testing to be performed with a signed consent form on file. To be medically necessary, tests must be ordered by a treating healthcare provider (or their authorized representative) who provides a consultation or treats a patient for specific medical problems and uses findings in the management of the patient.

Healthcare Provider Signature

Date DD / MMM / YYYY

Patient Clinical Information Responses to all questions **required**

1. Does the patient have a medical history of colorectal cancer, Hereditary Non-Polyposis Colorectal Cancer (HNPCC)/Lynch syndrome, or Familial Adenomatous Polyposis (FAP)? *If yes, the patient does not qualify for this test.* — Yes / No

2. Does the patient have a mutation in the *MLH1, MSH2, MSH6, MUTYH, PMS2,* or *APC* gene, or a diagnosis of a genetic syndrome that may be associated with elevated risk of colorectal cancer? *If yes, the patient does not qualify for this test.* — Yes / No

3. What is the patient's age? *This test is valid for patients aged 30 to 80 years.* — Age: ________

4. What is the patient's sex?
   - ☐ Male
   - ☐ Female

5. What is the patient's race/ethnicity? *If other, patient does not qualify for test. See note below.*
   - ☐ Caucasian
   - ☐ Other

6. Is the patient aware of any first-degree relative who has had colorectal cancer (father, mother, brother, sister, son, daughter)? — Yes / No

NOTE: GeneType for Colorectal Cancer is currently validated in patient's 30 years or older of Caucasian descent. Other ethnicities are under investigation but not yet available.

Internal Use Only
Date / Time Stamp

Place Barcode here

Phenogen Sciences, Inc.
1300 Baxter Street Suite 157
Charlotte, NC 28204

www.genetype.com
support@genetype.com
Phone: 704 926 5700 | Fax: 855 283 2360