Mainstream
Diagnostic Laboratory

A CLIA Accredited Laboratory
(844) 837-4780 I info@mainstreamlab.com

PLACE 1 BARCODE ON FORM AND 1 ON SAMPLE (REQUIRED: NAME/DOB)

CHECKLIST:
☐ Demographics/Medication List ☐ ICD-10 Codes ☐ ABN (Medicare)
☐ Physician & Patient Signatures ☐ Copy of Patient Insurance Card

CGx Requisition Form

First Name	*Last Name*	*Middle Initial*	Clinic Name

Social Security # | *Date of Birth* | *Sex* ☐ *F* ☐ *M* | *Ethnicity* ☐ *African American* ☐ *Asian* ☐ *Ashkenazi Jewish* ☐ *Caucasian* ☐ *Hispanic* ☐ *Other*

Address | *City* | *State* | *Zip* | *Phone*

INSURANCE: *Please provide a legible copy of the front and back of the patient's insurance card.* IF NO INSURANCE: ☐ Self Pay ☐ WC/Auto (Date of Injury) ☐ Other

Name of Insured | *Relationship to Patient* | *Insurance Company/Provider* | *Member/ID Number* | *Group Number*

Collector Name (Print) | *Date Collected* | *Time Collected* | *Fasting* ☐ Yes ☐ No

Specimen Type	*Specimen Storage*	*Specimen Shipping*
☐ 0CD-100 (Buccal)	☐ Room Temperature ☐ Refrigerated	☐ Room Temperature ☐ Cooling/Ice Pack

MOLECULAR DIAGNOSTICS TESTING OPTIONS

Cancer Genomics (CGx) *Please select the Panel to be tested. Please attach patient Medication List.*

☐ **Comprehensive Cancer**

☐ **Breast Cancer STAT (7-10 day TAT)**
ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, STK11, TP53

☐ **Breast Comprehensive**
ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, MLH1, MRE11, MSH2, NBN, NF1, PALB2, PTEN, RAD50, RAD51C, RAD51D, STK11, TP53, XRCC2

☐ **Breast and Ovarian 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

☐ **Gastric Comprehensive**
APC, BMPR1A, CDH1, CTNNA1, EPCAM, KIT, MLH1, MSH2, MSH6, NF1, PDGFRA, PMS2, SMAD4, STK11, TP53

☐ **Hematologic Malignancy Comprehensive**
ATM, BLM, CEBPA, EPCAM, GATA2, HRAS,MLH1, MSH2, MSH6, NBN, NF1, PMS2, RUNX1, TERC, TERT, TP53

☐ **Melanoma Comprehensive**
BAP1, BRCA2, CDK4, CDKN2A, CHEK2, MC1R, MITF, POT1, PTEN, RB1, SLC45A2, TP53, TYR

☐ **Thyroid Comprehensive**
APC, CHEK2, DICER1, PRKAR1A, PTEN, RET, TP53

☐ **Nervous System/Brain Comprehensive**
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

☐ **Ovarian Comprehensive**
BARD1, BRCA1, BRCA2, BRIP1, CDH1, EPCAM, MLH1, MRE11, MSH2, MSH6, NBN, PALB2, PMS2, RAD51C, RAD51D, SMARCA4, 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

☐ **Paraganglioma-Pheochromocytoma Comprehensive**
FH, MAX, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL

☐ **Prostate Comprehensive**
ATM, BRCA1, BRCA2, CHEK2, EPCAM, HOXB13, MLH1, MSH2, MSH6, NBN, PMS2, TP53

☐ **Renal/Urinary Comprehensive**
BAP1, CDC73, CDKN1C, DICER1, DIS3L2, EPCAM, FH, FLCN, GPC3, MET, MITF, MLH1, MSH2, MSH6, PMS2, PTEN, SDHA, SDHB, SDHC, SDHD, SMARCA4, SMARCB1, TP53, TSC1, TSC2, VHL, WT1

☐ **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

☐ **Custom**
Select genes to create a custom panel.

CGx Personal/Family History Questionnaire *Please complete Questionnaire*

PATIENT'S PERSONAL HISTORY (Hx)

Cancer/Tumor	Personal Hx	Age at Dx
Breast ☐ Triple negative (ER-, PR-, HER2-) ☐ Multiple primaries	☐ Yes ☐ No	
Ovarian ☐ Check if non-epithelial	☐ Yes ☐ No	
Prostate (Gleason score >7)	☐ Yes ☐ No	
Pancreatic	☐ Yes ☐ No	
Colon/Rectal	☐ Yes ☐ No	
Stomach	☐ Yes ☐ No	
Melanoma	☐ Yes ☐ No	

Other Cancer(s):

OTHER PERSONAL INFORMATION

☐ Bone marrow transplant
☐ Previous genetic testing for hereditary cancer
☐ Current diagnosis of a hematologic cancer

OTHER PERSONAL INFORMATION

Relationship	Maternal	Paternal	Cancer Site(s)	Age at Dx
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

ICD-10 DIAGNOSIS CODES: *Additional documentation supporting Medical Necessity may be attached.*

☐ C50.019 Malignant neoplasm of nipple and areola, unspecified female breast
☐ Z85.43 Personal history of malignant neoplasm of ovary
☐ C56.3 Malignant neoplasm of bilateral ovaries
☐ C56.9 Malignant neoplasm of unspecified ovary
☐ C61 Malignant neoplasm of prostate
☐ Z85.07 Personal history of malignant neoplasm of pancreas
☐ Z85.841 Personal history of malignant neoplasm of brain
☐ C71.0 Malignant neoplasm of cerebrum, except lobes and ventricle
☐ C54.1 Malignant neoplasm of endometrium
☐ C18.2 Malignant neoplasm of ascending colon
☐ Z85.51 Personal history of malignant neoplasm of bladder
☐ C73 Malignant neoplasm of thyroid gland
☐ Z85.850 Personal history of malignant neoplasm of thyroid
☐ C95.00 Leukemia not having achieved remission
☐ Z85.6 Personal history of leukemia
☐ C34.90 Malignant neoplasm of unspecified part of the bronchus or lung
☐ C80.1 Neoplasm, unspecified
☐ C16.9 Malignant neoplasm of stomach, unspecified
☐ C43.30 Malignant melanoma of unspecified part of face
☐ Other _____

Medical Necessity *Required for insurance*
☐ I, the provider, attest that I am the ordering physician or am authorized under applicable laws and regulations to order genetic testing for the patient. I attest that this test is medically necessary for the diagnosis or detection of a disease or disorder, and that the results will be used in medical management and care decisions for the patient. I further attest that any information entered on this Test Requisition Form, or otherwise provided by me on behalf of the patient, is true and correct to the best of my knowledge, and that the patient has consented to receive communications about his/her genetic test from Mainstream Diagnostic Laboratory.

Patient Informed Consent *Patient must consent*
☐ I, the patient, voluntarily consent to the collection and testing of my sample. I certify that the specimen is fresh and has not been adulterated in any manner. I authorize the laboratory to release the results of this testing to the ordering provider. I further authorize my insurance benefits to be paid directly to Mainstream Diagnostic Laboratory for services rendered. I acknowledge that the lab may be treated as an out-of-network provider. In the event I receive payment for laboratory services from my insurer, I will remit said payment to the lab within 14 days of receipt. I will either en-dorse the original check, or produce a personal check for the entire payment amount, and forward it to the lab. When selecting Self Pay above, I acknowledge financial responsibility for all lab charges associated with the processing of this test requisition. All rights to the samples will belong to the laboratory conducting the testing. There will be no compensation in the event of an invention resulting from research and development using this sample. I agree to allow my provided samples to be used for the purpose of (diagnosis/research) (development/quality control). I understand that if I agree, any information identifying me will be kept confidential so that it will not be possible to determine from whom the sample was drawn. Your signature on this form indicates that you understand to your satisfaction the information about Mainstream Diagnostic Laboratory and agree to have the test done. In no way does this waive your legal rights or release anyone from their legal and professional responsibilities. If you have further questions concerning matters related to this consent, you may wish to seek professional genetic counseling prior to signing this form. Consultation with a medical geneticist, genetic counselor, or your referring healthcare provider also may be warranted after the test has been completed.

Opt In for Research
☐ I give permission for my sample and clinical information to be used in de-identifi ed studies at Mainstream Diagnostic Laboratory and for publication, if Mainstream Diagnostic Laboratory deems it appropriate. I understand that my name and/or other identifying information will NOT be used in or linked to the results of any studies and publications. More information is available at www.mainstreamlab.com.

Provider Name (Print)	***Provider NPI #***	*Clinic Address*	*Clinic Phone/Fax*

Provider Signature	***Date***	***Patient Signature (or Legal Guardian)***	***Date***
X		X	