riskguard™

Hereditary Cancer Test

All fields required unless noted as optional

3800 S. Business Park Ave Marshfield, WI 54449

Phone 866-662-6897 | Fax 715-406-4175 | Email riskguard@exactsciences.com

Please fax completed order form to 715-406-4175 before including in the Exact Sciences' Specimen Collection Kit

Exact Sciences use only

EXACT SCIENCES

Patient Information

Last (Family) Name | First Name | MI | DOB (MM/DD/YYYY)

Address | City | State | ZIP

Patient ID / Medical Record Number (Optional) | Phone Number | Email

Geoancestry / Ethnicity

- ☐ Ashkenazi Jewish
- ☐ Black or African American
- ☐ East Asian
- ☐ First Nations
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ South Asian
- ☐ Other:

Sex at Birth

☐ Female ☐ Male ☐ Other:

Primary ICD-10 Code

Billing Information

☐ Medicare ☐ Private insurance ☐ Medicaid ☐ Patient (Domestic-US) ☐ Patient (Non-US) ☐ Account (restricted to contracted accounts on file)

Primary Insurance | Policy Number

Patient Status - Medicare only (at sample collection)

☐ Hospital Inpatient (>24 hours stay) ☐ Hospital Outpatient ☐ In-office procedure

Inpatient Discharge Date:

Group # | Subscriber Name | Primary Policy Holder

IF PRIMARY INSURANCE IS LEFT BLANK, OR IF SECONDARY INSURANCE IS AVAILABLE, ENSURE A FACE SHEET AND COPY OF INSURANCE CARD ARE ATTACHED, OR YOU MAY BE CONTACTED.

Specimen Collection

Has patient undergone chemotherapy within last 2 weeks? ☐ Yes ☐ No ☐ Unknown

Specimen Collection Date

Specimen Source: ☐ Blood ☐ Saliva ☐ Buccal

Blood Transfusion: ☐ No ☐ Yes, within last 30 days. Date: Type:

Bone Marrow Transplant: ☐ No ☐ Yes Date:

Test Selection

Test Code	Panel Name	Description	Special Instructions
15707	**riskguard**	Riskguard is a multi-cancer multigene test that identifies germline variants that may impact clinical decision-making in breast, prostate, colorectal, endometrial, gastric, ovarian, pancreatic, melanoma, renal, lung, and endocrine cancers	☐ **Specimen Collected in New York State** MUST include Genetic Testing Healthcare Provider Statement. **SP205**

Ordering Provider Reporting Information

Name | NPI # | Email

Office / Practice / Institution | Phone | Fax

Address | Contact Name | Contact Phone | Contact Email

Additional Report Recipient (Optional)

Name | Phone | Fax | Email

Ordering Provider Signature and Attestation

As the ordering Healthcare Provider, I certify that: (1) I am a qualified healthcare provider who is legally authorized to order this test. I am the treating practitioner, and this testing is medically necessary and appropriate for this patient and the results will be used to determine the patient's treatment plan; (2) I have obtained the patient's informed consent to perform this test as documented on a signed consent form that complies with applicable law; (3) I have received the patient's consent for your laboratory to release test results and submit all necessary information to insurance for payment and genetic counseling if needed; and (4) I understand this testing will be based on the most updated requisition and test description available. I further confirm the patient has been appropriately counseled and understands the risks, benefits, and limitations of this genetic testing and the implications of the results.

Ordering Provider Signature | Printed Name | Date (MM/DD/YYYY)

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Patient

Last (Family) Name

First Name

DOB (MM/DD/YYYY)

Cancer History

Patient Information

☐ **No personal history of cancer**

☐ **Breast**
Age of diagnosis: ____
- ☐ Triple-Negative (ER, PR, Her2 negative)
- ☐ DCIS (Ductal Carcinoma In Situ)
- ☐ IDC (Invasive Ductal Carcinoma)
- ☐ ILC (Invasive Lobular Carcinoma)
- ☐ Bilateral / >1 Primary

☐ **Ovarian/Fallopian Tube / Primary Peritoneal**
Age of diagnosis: ____

☐ **Colorectal**
Age of diagnosis: ____
MSI/IHC results: ____

☐ **Endometrial / Uterine**
Age of diagnosis: ____
MSI/IHC results: ____

☐ **Pancreatic**
Age of diagnosis: ____

☐ **Prostate**
Age of diagnosis: ____
Metastatic ☐ Yes ☐ No ☐ Unknown
Gleason score: ____

☐ **Polyps**
Age of diagnosis: ____
Number of polyps: ____
Pathology details: ____

☐ **Other**
Age of diagnosis: ____
Details: ____

Family History of Cancer

☐ **No known family history of cancer**

☐ **Limited Family Structure**

Limited family history available such as fewer than two female first or second-degree maternal or paternal relatives having lived beyond age 45.

Relation to Patient	Select	Cancer / Polyp Type / Gleason Score	Age of Diagnosis	Unavailable for Testing	Relative is Deceased	Patient has No Contact with Relative	Relative Declines Testing
	☐ Maternal ☐ Paternal			☐	☐	☐	☐
	☐ Maternal ☐ Paternal			☐	☐	☐	☐
	☐ Maternal ☐ Paternal			☐	☐	☐	☐
	☐ Maternal ☐ Paternal			☐	☐	☐	☐
	☐ Maternal ☐ Paternal			☐	☐	☐	☐

Past Family Genetic Testing

☐ NO previous testing in family

☐ YES, Include Germline, Somatic or Tumor testing results. Attach copies of report.