PREVENTION GENETICS part of EXACT SCIENCES

Test information is available on our website:
exactsciences.com/riskguard

PREVENTIONGENETICS USE ONLY

THIS FORM MUST ACCOMPANY ALL SPECIMENS

AND SENT TO
3800 S. Business Park Ave., Marshfield, Wisconsin 54449 USA
OR FAX: **(715) 406-4175**

riskguard™

Hereditary Cancer Test

☐ Please ship one Saliva Kit to patient's home address.

PERSON COMPLETING FORM	CONTACT (PHONE OR EMAIL)

PATIENT INFORMATION

LAST (FAMILY) NAME	FIRST NAME	MI	DATE OF BIRTH
			___ / ___ / ___ (MONTH / DAY / YEAR)

ADDRESS	CITY	STATE	ZIP

PATIENT ID / MEDICAL RECORD NUMBER	PHONE NUMBER	EMAIL

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

BIOLOGICAL SEX
- ☐ Male ☐ Female
- ☐ Other

_____ (SPECIFY KARYOTYPE)

BLOOD TRANSFUSION
- ☐ NO
- ☐ Within Last 30 Days, Date and Type

___ / ___ / ___ (MONTH / DAY / YEAR)
TYPE _____

BONE MARROW TRANSPLANT
- ☐ NO
- ☐ YES, Date

___ / ___ / ___ (MONTH / DAY / YEAR)

SPECIMEN COLLECTION DATE
___ / ___ / ___ (MONTH / DAY / YEAR)

SPECIMEN SOURCE
- ☐ Whole Blood ☐ Saliva
- ☐ Buccal

ICD-10 CODES
1 PRIMARY_____ 2 _____ 3 _____

BILLING INFORMATION

INDICATE BILL TYPE: ☐ **MEDICARE,** ☐ **OTHER INSURANCE,** ☐ **SELF-PAY (PATIENT),** ☐ **UNINSURED**

POLICY HOLDER NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
	___ / ___ / ___ (MONTH / DAY / YEAR)	

PRIMARY INSURANCE COMPANY NAME (REQUIRED)	PHONE NUMBER

POLICY ID#	GROUP #	AUTHORIZATION # ☐ *Attach copy of authorization, Genomic Health Inc. must be listed as servicing provider.*

SECONDARY INSURANCE ☐ *Attach a copy of Insurance Card (both sides)*

HOSPITAL STATUS (MEDICARE ONLY)
☐ **Hospital Inpatient** *(>24 hour stay)* ☐ **Hospital Outpatient** ☐ **In-Office Procedure**
└ **Discharge Date** _____

BENEFITS INVESTIGATION
☐ **Complete benefit investigation and contact patient via email provided with coverage information.**
If benefits investigation is not requested, patient assumes financial responsibility for test.

TEST SELECTION

TEST CODE	PANEL NAME	DESCRIPTION	SPECIAL INSTRUCTIONS
☑15707	riskguard™ Hereditary Cancer Test	**Panel includes 32 clinically actionable genes.** Gene list: *APC, ATM, AXIN2, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, EPCAM, GREM1, HOXB13, MLH1, MSH2, MSH3, MSH6, MUTYH, NBN, NTHL1, PALB2, PMS2, POLD1, POLE, PTEN, RAD51C, RAD51D, SMAD4, STK11, TP53*	☐ **SPECIMEN COLLECTED IN NEW YORK STATE** MUST include Genetic Testing Healthcare Provider Statement. **SP205**

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PREVENTIONGENETICS USE

PATIENT

LAST NAME

FIRST NAME | MI

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: _____
_____
_____

Has patient undergone chemotherapy within last 2 weeks?
☐ yes ☐ no ☐ unknown

FAMILY HISTORY OF CANCER

☐ **No known family history of cancer**

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.*

☐ **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.

ORDERING / TREATING PROVIDER REPORTING INFORMATION

Our preferred method of report transmission is uploading to our secure web portal.
Please provide an email address, when possible. If you have additional specific reporting requests, indicate them BELOW.

INSTITUTION NAME

ADDRESS		**CITY**	**STATE**	**ZIP**
ORDERING PROVIDER (First, Last, Degree)	**NPI#**	**ADDITIONAL PROVIDER, if applicable** (First, Last, Degree)	**NPI#**	
EMAIL ADDRESS *For report access via secure portal*	**PHONE NUMBER**	**EMAIL ADDRESS** *For report access via secure portal*	**PHONE NUMBER**	

IF YOU REQUIRE REPORTS TO BE TRANSMITTED VIA ANOTHER SECURE METHOD, SPECIFY HERE.

ORDERING / TREATING PROVIDER ATTESTATION

With my signature below, 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 educated the patient and have received the patient's informed consent to proceed with testing; (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.

HEALTHCARE PROVIDER SIGNATURE | **PRINTED NAME** | **DATE**