LCA Use Only. Please place accessioning sticker here.

Clinical Questionnaire for **Hereditary Cancer** (one test per form)

This is not an order for a test. This form should be completed by the ordering provider's office (and signed by the patient).

Please select the appropriate process and complete this form in its entirety. **If you have questions best answered by a genetic counselor prior to proceeding, please call 800-345-4363. If you have questions about this form, please contact Prior Authorization at 855-488-8750.**

Patient understands by signing below:
LabCorp may use information obtained on this form and other information provided by me and/or my ordering provider or his/her designee to initiate preauthorization with my health plan as required. I understand a preauthorization approval from my health plan does not guarantee full payment.

LabCorp will make 3 attempts to contact me if my estimated out-of-pocket payment is more than $300. If a sample has been received, testing may be canceled if LabCorp is unable to reach me. No matter my estimated payment amount, my actual out-of-pocket expense may be higher or lower than the estimate LabCorp may provide. It is my responsibility to contact my insurance company regarding concerns over my coverage and benefits.

○ In the event I cannot be reached, LabCorp may leave a confidential voicemail message related to hereditary cancer testing at the telephone number provided below.

○ **Submitting completed questionnaire with sample**
○ **Submitting for prior authorization only, please include the patient's address and a copy of their insurance card (front and back)**
(form can be e-mailed to PriorAuth@LabCorp.com or faxed to 855-711-5699, attention: Prior Authorization)

Patient's Signature (required) ______________________ **Telephone** ______________

Patient/Provider Information

Patient's name: ______________ / Date of birth: ______________ / Gender: ○ Male ○ Female
Name and title of person completing form: ______________ / Date form completed: ______________
Provider's name and **signature:** ______________ / NPI: ______________
Provider's account #: ______________ / Provider's phone #: ______________ / Provider's fax #: ______________

Patient History

Has genetic counseling been performed? ○ No ○ Yes, **please attach report** Genetic counselor name ______________ Phone # ______________
Has patient had previous genetic testing for inherited cancer predisposition? ○ No ○ Yes, **please attach report**

○ **No personal history**
○ **Breast cancer or DCIS,** age at Dx ______ (Check all that apply)
☐ Bilateral ☐ Premenopausal ☐ Triple negative (ER-,PR-,HER2-)
○ **Ovarian cancer,** age at Dx ______
○ **Endometrial cancer,** age at Dx ______
○ **Other cancer** ______________, age at Dx ______

○ **Colorectal,** age at Dx ______
MSI Results: ☐ High ☐ Low ☐ Stable **IHC Results:** If present, specify results ______
○ **Renal,** age at Dx ______
○ **Pancreatic cancer,** age at Dx ______
○ **Prostate cancer,** age at Dx ______, Gleason Score ______
○ **History of bone marrow transplant,** date last transplant performed ______

VistaSeq® Panel Options: Please choose the most appropriate panel *(Visit www.labcorp.com for detailed information on genes included in each panel)*

○ VistaSeq® - 27 Genes / 481220	○ VistaSeq® w/o *BRCA* - 25 Genes / 481240	○ Pancreatic - 14 Genes / 481385
○ Breast - 19 Genes / 481319	○ Gyn - 11 Genes / 481330	○ Endocrine - 13 Genes / 481374
○ Breast - 9 Genes / 481452	○ Colorectal - 7 Genes / 481352	○ Renal - 19 Genes / 481407
○ Breast & Gyn - 25 Genes / 481341	○ Colorectal - 22 Genes / 481363	○ Brain/CNS/PNS - 17 Genes / 481386

Required
ICD-10 Diagnosis Code(s)

BRCA*ssure*® Test Options: Please choose the most appropriate test

○ *BRCA1/2* Comprehensive Analysis / 252911	○ *BRCA1/2* Ashkenazi Jewish Profile / 252970	○ *BRCA1/2* Deletion/Duplication Analysis / 252888
○ *BRCA1* Targeted Analysis | Mutation: ______ / 252235	○ *BRCA2* Targeted Analysis | Mutation: ______ / 252250	

Family History (Please attach pedigree or complete the table below.)

Have any family members had a **positive** genetic test related to a hereditary cancer syndrome? ○ No ○ Yes, **please attach the relative's lab report**
Unknown or limited family history? Please explain (eg, adopted) ______________

Relationship*	**Maternal or Paternal**	**Relative Available for Testing?** If no, please state reason.	**Known Mutation?** If yes, please attach lab report	**Cancer Type**	**Age At Diagnosis**

* Relationships to consider include parents, siblings, offspring (1st degree), half-brothers/sisters, aunts/uncles, grandparents, grandchildren, nieces/nephews (2nd degree); first cousins, great-aunts/uncles, great-grandchildren, great grandparents (3rd degree).

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