AT THE FOREFRONT UChicago Medicine | Medical Laboratories

Cancer Requisition Form

Client Account Code:

If code not known or client account not set up, contact Venessa Gamboa at 312-213-5441.

The University of Chicago Genetic Services Laboratories
5841 South Maryland Avenue, Room G701/MC0077, Chicago, IL 60637
Toll Free: 888.824.3637 | Local: 773.834.0555 | Fax: 773.702.9130
ucglabs@bsd.uchicago.edu | dnatesting.uchicago.edu | CLIA#: 14D0671659 | CAP#: 18827-01

Patient Information

Name: *Last*_____ *First*_____ Date of Birth: _____

Sex assigned at birth: ☐ Female ☐ Male MRN: _____

Ancestry: ☐ European ☐ African-American ☐ Hispanic ☐ Asian ☐ Ashkenazi Jewish ☐ Other _____

Ordering Physician Information

☐ Referring Physician: _____

Phone:_____ Fax:_____

Email:_____

☐ Genetic Counselor: _____

Phone:_____ Fax:_____

Email:_____

☐ Referring Lab:_____

Phone:_____ Fax _____

Email: _____

Patient Clinical History*

REQUIRED INFORMATION. NECESSARY FOR TESTING

Indication for testing and ICD-10 code for testing: _____

☐ No Personal history of cancer

☐ Personal history of cancer, type(s):_____ Age at diagnosis: _____

Results of previous genetic testing: _____

We recommend also providing detailed clinic notes results of previous genetic testing and a detailed family pedigree to aid in interpretation of genetic findings.

Patient Family History

REQUIRED INFORMATION. NECESSARY FOR TESTING

☐ No Family History of Cancer

☐ Family history of cancer – please specify cancer types, ages of onset and relationship to patient: _____

_____

☐ Other relevant family history:_____

Sample Information

Date Sample Drawn:_____ Specimen Type: ☐ Fibroblast Culture ☐ Skin Biopsy ☐ Peripheral Blood*** ☐ DNA*** ☐ Buccal swab*** ☐ Saliva***

***Skin biopsies must be cultured prior to testing. A culturing fee will be charged for all skin biopsy samples received. Please note, culturing adds 2-3 weeks to the turnaround time for testing.

***Peripheral blood or DNA extracted from blood sample is not accepted for patients with a current or past diagnosis of MDS or leukemia, or who have a history of bone marrow transplant. Please send fibroblast culture or skin biopsy instead. Skin fibroblast samples are preferred for patients with lymphoma, however blood can be accepted ONLY if there is no blood involvement. Blood is accepted for patients with bone marrow failure disorders unless they have a history of MDS/leukemia. Saliva/buccal samples are not recommended for patients with hematological malignancies such as MDS/leukemia. Please contact the laboratory for further information.

Specimen Requirements: 2X T-25 flasks of cultured fibroblasts or 3-10cc blood in an EDTA (purple top) tube (if sending blood sample, please see above note). DNA samples are only accepted if the DNA

Ordering Checklist

☐ Test Requisition Form *(required)*
☐ Completed Indication for Testing/ICD-10 study code *(required)*
☐ Completed Billing Information *(required)*
☐ Completed Research Consent Form *(recommended)*

For Office Use Only

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Acute Leukemia testing

**Note: blood samples not accepted for patients with a previous diagnosis of MDS/leukemia. Skin fibroblast culture recommended.

☐ Hereditary Leukemia and Breast Cancer Panel

Hereditary Breast and Ovarian Cancer testing

☐ Hereditary Breast and Ovarian Cancer Panel
☐ Hereditary Leukemia and Breast Cancer Panel

Hereditary Cancer (Multiple Types) testing

☐ Comprehensive Hereditary Cancer Panel

Hereditary Colorectal Cancer testing

☐ Hereditary Colorectal Cancer Panel
☐ Lynch Syndrome Panel

Hereditary Gastric Cancer testing

☐ Hereditary Gastric Cancer Panel

Hereditary Lymphoma testing

**Note: skin fibroblast culture preferred for patients with a previous diagnosis of lymphoma. Blood accepted only if there is no blood involvement.

☐ Hereditary Lymphoid Malignancy/Immunodeficiency Predisposition Panel

Hereditary Melanoma testing

☐ Hereditary Melanoma Panel

Hereditary Myeloid Malignancy testing

**Note: blood samples not accepted for patients with a previous diagnosis of MDS/leukemia. Skin fibroblast culture recommended.

☐ Hereditary Myeloid Malignancy Panel

Hereditary Hematopoietic Malignancy testing

**Note: blood samples not accepted for patients with a previous diagnosis of MDS/leukemia. Skin fibroblast culture recommended.

☐ Hereditary Hematopoietic Malignancy/Immunodeficiency Predisposition Panel

Hereditary Paraganglioma and Pheochromocytoma testing

☐ Hereditary Paraganglioma and Pheochromocytoma Panel

Hereditary Prostate Cancer testing

☐ Hereditary Prostate Cancer Panel

Hereditary Thyroid Cancer testing

☐ Hereditary Thyroid Cancer panel

Inherited Bone Marrow Failure Disorders

**Note: Blood accepted for patients with bone marrow failure ONLY if there is no history of MDS/leukemia.

☐ Inherited Bone Marrow Failure Panel (includes all genes from 4 panels below)
☐ Telomere Biology Disorder / Dyskeratosis Congenita Panel
☐ Fanconi Anemia Panel
☐ Diamond-Blackfan Anemia Panel
☐ Severe Congenital Neutropenia Panel

Thrombocytopenia

☐ Thrombocytopenia Panel

Targeted Variant Analysis

(Testing for a previously detected variant or sequence change)
Requires prior approval by UCGS Lab Staff if this is a gene for which we do not offer full sequencing.

Gene:_____ Change:_____

☐ Symptomatic ☐ Asymptomatic

Name of Proband or UoC Lab Number: _____

Relationship to proband: _____

Single Gene Analysis

Any gene included in one of our panels can also be ordered individually. Please contact UCGS Lab Staff for prior approval before ordering. Gene Requested: _____

☐ Exome Select

Requested Genes (required):

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BILLING OPTIONS

Samples received with incomplete billing information will delay processing time.

Test canceled while "in progress" will be billed for the amount of work completed up to that point.

For client account or institutional billing questions: venessa.gamboa@uchicagomedicine.org or call 312-213-5441.
For insurance or patient billing questions: 1-844-843-3594.

Client Account Code:

Patient Name: *Last*_____ *First* _____(MI):_____Date of Birth: _____

1.) Institutional Billing

Billing Institution and Client Account Code_____PO#:_____

Financial Contact:_____Phone:_____Fax:_____

Address:_____City:_____State:_____Zip: _____

Email (required): _____

2.) Insurance Billing

PLEASE NOTE: *We do NOT accept Illinois or any out-of-state Medicaid.* ***A legible photocopy of the front and back of the insurance card and insurance prior authorization MUST BE INCLUDED.*** *A completed and signed ABN is* ***REQUIRED*** *for Medicare patients. Please contact us at 1-844-843-3594 for insurance or patient billing questions.*

ICD-10 Diagnosis Code(s):_____ (***Must be provided or insurance cannot be filed.)***

Policyholder Name: _____ Date of Birth:_____Sex: ☐ Male ☐ Female

Policyholder Address:_____City:_____State:_____Zip:_____

Relationship to the Patient: ☐ Self ☐ Spouse ☐ Dependent ☐ Other Preauthorization # (***required***): _____

Name of Primary Insurance:_____Policy No._____Group No.: _____

Insurance Address:_____City:_____State:_____Zip:_____

PCP/Referring Physician Name:_____NPI #: _____

Name of Secondary Insurance:_____Policy No.:_____Group No.: _____

Insurance Address:_____City:_____State:_____Zip: _____

The policy holder's signature to the following statement: I hereby authorize any physician who treated or attended to me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I hereby transfer and assign to the University of Chicago Genetic Services Laboratories any benefits of insurance I may have. I assume responsibility for the balance of the cost of testing not paid by my insurance company. A photocopy of this authorization shall be considered as effective and valid as original.

Authorized Signature:_____Date:_____

See our QuickGuide to Genetic Testing for complete list of Tests, TAT and CPT Codes.

CONSENT/AUTHORIZATION BY SUBJECT FOR PARTICIPATION IN A RESEARCH PROTOCOL FOR THE BETTER UNDERSTANDING OF THEIR GENETIC CONDITION

Protocol Number: 11-0151

Name of Subject : _____

Date of Birth: _____

STUDY TITLE: Molecular Genetic Studies of Rare Orphan Genetic Disease

Research Team: Soma Das, Ph.D.
5841 S. Maryland Ave. Room L-155 MC 0077, Chicago, IL 60637
773-834-0555

You are being asked to allow your child to participate in a research study that may help us learn more about the genetic condition for which you are being tested. This consent form describes the study, the risks and benefits of participation, as well as how your confidentiality will be maintained. Please take your time to contact us with questions and feel comfortable making a decision whether to participate or not. If you decide to participate in this study, please sign this form**. Throughout this consent form, "you" will refer to you or your child, as appropriate.**

WHY IS THIS STUDY BEING DONE?

You have already consented to clinical genetic testing. We are asking you to also participate in further studies. The purpose of these studies is to learn more about the genetic cause of diseases tested for in our lab, gather more information about these disorders, and experiment with new methods that may be better for testing.

WHAT IS INVOLVED IN THE STUDY?

During this study, Dr. Das and her team will collect information about you for this research. We may contact your doctor to request additional Protected Health Information (PHI), which consists of any health information related to your diagnosis (such as date of birth, medical record number, primary diagnosis, clinical features, relevant and family history, outcome). The data collected will be used to develop a database of patients being tested for genetic diseases and will be kept for the duration of the database. This study will look at how often different genetic mutations happen and clinical information related to the mutation.

When our lab is researching new genes or testing methods that are related to your diagnosis, we may include your sample, with others from similar patients in a small study before offering this new test. This data will help in directing doctors about the likelihood of a positive or negative test result in their patient. We may also use your sample to set up new methods that will improve the clinical testing in our laboratory. Your clinical information and sample, without any identifiers, may also be shared with other researchers that are interested in this specific condition.

HOW LONG WILL I BE IN THE STUDY?

Once enrolled, you will likely remain in this study as long as your DNA sample remains in our laboratory. If you want your sample, to be removed from the study at any time, please contact us, and the sample will not be used for further studies. Existing results will remain in our database until the study ends.

WHAT ARE THE RISKS OF THE STUDY?

There are no known added risks of the research. No additional information will be obtained from you, as all of the information has already been collected as part of clinical genetic testing or evaluation by your doctor.

ARE THERE ANY BENEFITS TO TAKING PART IN THE STUDY?

If you agree to take part in this study, there may be direct medical benefit to your family. We may identify a cause for the genetic disease in your family. If a mutation is identified in your DNA, through our testing, your referring doctor will be notified and will receive a clinical report. Our study may also be helpful in finding the genetic causes of disease and will benefit doctors and patients as a group.

WHAT OTHER OPTIONS ARE THERE?

You may choose not to participate.

WHAT ARE THE COSTS?

There will be no additional costs to you or your insurance company resulting from this research study. However, you or your insurance company will be responsible for costs related to your usual medical care.

WILL I BE PAID FOR MY PARTICIPATION?

You and your child will not be paid to participate.

WHAT ABOUT PRIVACY?

Study records that identify you will be kept private. All of your personal information will be entered into a password-protected database to prevent access to non-authorized personnel. If your data is shared with other researchers, all patient identifiers will be removed. Data from this study may be used in medical journals or presentations. If results from this study or related studies are made public in a medical journal, individual patients will not be identified. If we wish to use a patient's identity in a medical journal, we will ask for your permission at that time.

As part of the study, Dr. Das and her team will report any positive results of further testing to your referring doctor and/or genetic counselor. Dr. Das may also share these results, without your name or date of birth, with other researchers.

People from the University of Chicago, including the Institutional Review Board (IRB), a committee that oversees research at the University of Chicago, may also view the records of the research. If health information is shared outside the University of Chicago, the same laws that the University of Chicago must obey may not protect your health information. Dr. Das does not have to give you any results that are not are not important to your health or your family's health at that time.

This consent form will be kept by the research team for at least six years. The study results will be kept in your child's research record and be used by the research team indefinitely. When the study ends, your personal information will be removed from all results. Any information shared with your doctor may be included in your medical record and kept forever.

The Genetic Information Nondiscrimination Act (GINA) is a federal law that may help protect you from health insurance or employment discrimination based on genetic information. GINA is a federal law that will protect you in the following ways:

- Health insurance companies and group plans may not request genetic information from this research;
- Health insurance companies and group plans may not use your genetic information when making decisions regarding your eligibility or premiums;
- Employers with 15 or more employees may not use your genetic information when making a decision to hire, promote, or fire you or when setting the terms of your employment.

GINA does not protect you against genetic discrimination by companies that sell life insurance, disability insurance, or long-term care insurance. GINA also does not protect you against discrimination based on an already-diagnosed genetic condition or disease.

WHAT ARE MY RIGHTS AS A PARTICIPANT?

Taking part in this study is optional. You may choose not to participate at any time during the study. Choosing not to participate or leaving the study will not affect your child's testing at the University of Chicago.

If you choose to leave the study and you do not want any of your child's future health information to be used, you must inform Dr. Das in writing at the address on the first page. Dr. Das may still use your child's information that was collected before to your written notice. You will be given a signed copy of this form. This consent form does not have an expiration date.

WHO DO I CALL IF I HAVE QUESTIONS OR PROBLEMS?

If you have further questions about the study, please call 773-834-0555.

If you have any questions about your rights in this research study you may contact the IRB, which protects participants in research projects. You may reach the Committee office between 8:30 am and 5:00 pm, Monday through Friday, by calling (773) 702-6505 or by writing: University of Chicago, Institutional Review Board, 5841 S. Maryland Ave., MC7132, I-625, Chicago, IL 60637.

Consent

I have received information about this research project and the procedures. No guarantee has been give about possible results. I will receive a signed copy of this consent form for my records.

I give my permission to participate in the above research project.

Signature of Subject: _____

Date: _____

I give my permission for my child/relative/the person I represent to participate in the above research project.

Signature of Parent/Legal Guardian/Legally Authorized Representative:

_____

Date: _____