BRCA 1/2 GENETIC TESTING REQUISITION

1-844-363-4357
Ask.Genetics@LifeLabs.com

Appointment booking can be done at www.lifelabs.com

Schillingallee 68 · 18057 Rostock Germany

CONTRACT #	**LL: K012-01 / BC: no contract# (private pay)**	**LifeLabs Demographic Label**
Ordering Physician #	Physician OHIP# (Ontario): Physician MSC# (British Columbia): Other Provinces: 999 (Ontario voyager)	
Ordering Physician Name	Name	
Ordering Physician Address & contact info:	Address Tel: Fax:	**Additional Label** (if needed)
Physician Signature:	**Confirmation of patient consent:** I confirm that this patient has given consent to testing as may be required by applicable law. I have provided the patient with the Patient Information form and the opportunity for pre-test counselling, where details associated with the genetic test(s) ordered below including its risks, benefits and limitations are discussed. I have encouraged the patient review the result of testing with the appropriate genetic counseling. I can confirm that the patient was informed that s/he has the right to revoke his/her consent at any time. **I authorize that the patient receives a copy of the test results in addition to summary letters of the counseling sessions, unless I check the box below.** ❑ I do NOT authorize that the patient receives a copy of the test results or summary letters directly and I have made the patient aware of this. Please sign here	
Copy-to Client: ❑ Genetic Counsellor ❑ Other Healthcare Provider	Copy-to Client name Tel: Fax:	
Bill to:	**Bill Type "Private Pay"** (ON: P; BC: PP; patient pays at time of collection)	**Patient Sex**: ◻ **Female** ◻ **Male**

Patient Last Name:	**Patient First Name:**	**Patient Health Card:**		**Date of Birth:** M M D D Y Y Y Y
Unit #:	**Street:**	**City:**	**Prov.:**	**Postal Code:** / **Patient Telephone:** ( ) -
Patient email:		*If the ordering physician authorizes the patient to receive results and summary letters, it is LifeLabs' preference to release these documents via email.*		

TEST REQUESTED

	ON-LL TR#	Mnemonic
❑ **Genetic Counselling + BRCA 1/2 analysis** (for LL Genetics) - **$600** *TAT: 4-6 weeks*	**5501**	**BRCALL**
❑ **Expedited Genetic Counselling + BRCA 1/2 analysis** (for LL Genetics) - **$850** *TAT: 2-3 weeks*	**5520**	**BRCALLXP**

Date Sample Collected	M M	D D	Y Y Y Y	**Time Collected**	H H	M M	**Collector Name:**	

GENETIC TESTING CONSENT

I have read the Patient Information Form. I understand that my specimen for DNA analysis will be sent to LifeLabs for genetic testing. LifeLabs and Centogene have entered into a mutually binding distribution agreement whereby both organizations will comply with all applicable legislation. Centogene complies with German confidentiality laws; LifeLabs Genetics complies with Canadian privacy laws. LifeLabs will only report test results to the ordering healthcare provider(s) or genetic counsellors involved and the patient when authorized by the ordering healthcare provider to do so. Additionally, the test results could be released to those who, by law, may have access to such data. My physician has told me about the condition(s) being tested and its genetic basis. I am aware that correct information about my family members is important and can affect the outcome of my results. I agree that my specimen and personal health information may be sent to Centogene AG at their laboratory in Germany (address above). To ensure accurate testing, I agree that the results of genetic testing that I have had previously completed by Centogene AG may be shared with LifeLabs. I understand that LifeLabs will contact me for a new specimen if a test result cannot be provided from the original specimen. I agree that a copy of my results will be sent to my ordering physician. I further agree that for any test(s) performed by Centogene AG, a copy of my results will also be sent to LifeLabs.

1. I understand that once the requested test(s) has/have been completed, any remaining sample will be stored at the testing laboratory.
2. I agree that my de-identified sample may be used for product development or research purposes. I understand that I will not receive any royalties, resultant payments, benefits or rights to products or discoveries.

❑ I do not want my remaining sample or data from my results to be stored and/or used for product development or research purposes. Please destroy any remaining sample once the final report has been issued. By ticking this box I disagree with points 1 and 2 listed above.

Patient/Substitute Decision Maker: Signature: _____; Date: _____

Printed name: _____; Relationship to person being tested: _____

OR: I certify that verbal consent was obtained from the patient /substitute decision maker for the requested genetic testing
Signature of Physician : _____; Date: _____

****PHOTOCOPY REQUISITION AND INCLUDE 1 COPY WITH SAMPLES****

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Testing Instructions: Please use the online catalogue to find test code & names: **www.lifelabsgenetics.com /hereditary-conditions**	**Test Code(s):** CN5046 **Test Name(s):** BRCA1/BRCA2 Panel **Test methodology** ☒ FULL ANALYSIS - *sequencing+ reflex to deletion/duplication* ❑ URGENT ANALYSIS REQUESTED (*only check marked if Expedited Genetic Counselling + BRCA1/2 has been selected on page 1)* ❑ Familial Mutation (*Familial Report attached* **Y/N**) *Gene:*_____ *Mutation (HGVS)*:_____
Sample Type:	☒ ***Blood** (EDTA: 8- 10mL) ❑ **Saliva** (Oragene OG-510, available by request)
Patient Information:	❑ African ❑ Caucasian ❑ French Canadian or Cajun ❑ Middle Eastern ❑ Northern European *e.g. British, German* ❑ South Asian *e.g. Indian, Pakistani* ❑ East Asian *e.g. Chinese, Japanese* ❑ Ashkenazi Jewish ❑ Other/Mixed Caucasian ❑ Indigenous ❑ Hispanic ❑ Southern European *e.g. Italian, Greek* ❑ Southeast Asian *e.g. Filipino, Vietnamese* ❑ Pacific Islander ❑ Other – *please specify:* _____
	Additional patient medical information: **Relevant family history:**
	Have other family members submitted samples to LifeLabs/Centogene for analysis? ❑Y ❑ N If yes, Name:_____ Relationship to patient _____ DOB *(MM/DD/ YYYY)*:_____
Billing Status:	☒ **Institution** *(Complete information below)*
Institution Billing ONLY:	**Institution Name:** _____ **Contact Name:** _____ **Address:** **Phone:** (____)____-____ **Fax:** (____)____-____ **Email:** _____

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