

<b>CONTRACT #</b>		<b>LL: K012-01 / BC: no contract# (private pay)</b>				<b>LifeLabs Demographic Label</b>											
<b>Ordering Physician #</b>		Physician OHIP# (Ontario): Physician MSC# (British Columbia): Other Provinces: 999 (Ontario voyager)															
<b>Ordering Physician Name</b>		Name															
<b>Ordering Physician Address &amp; contact info:</b>		Address				<b>Additional Label (if needed)</b>											
		Tel: _____ Fax: _____															
<b>Physician Signature:</b>		<p><b>Confirmation of patient consent:</b> 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 <b>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.</b></p> <input type="checkbox"/> 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															
<b>Copy-to Client:</b> <input type="checkbox"/> Genetic Counsellor <input type="checkbox"/> Other Healthcare Provider		Copy-to Client name															
		Tel: _____ Fax: _____															
<b>Bill to:</b>		<b>Bill Type "Private Pay"</b> (ON: P; BC: PP; patient pays at time of collection)			<b>Patient Sex:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male												
<b>Patient Last Name:</b>		<b>Patient First Name:</b>		<b>Patient Health Card:</b>		<b>Date of Birth:</b>											
						M   M   D   D   Y   Y   Y   Y											
<b>Unit #:</b>	<b>Street:</b>	<b>City:</b>	<b>Prov.:</b>	<b>Postal Code:</b>	<b>Patient Telephone:</b>												
					( ) -												
<b>Patient email:</b>				If the ordering physician authorizes the patient to receive results and summary letters, it is LifeLabs' preference to release these documents via email.													
<b>TEST REQUESTED</b>																	
<input type="checkbox"/> <b>Genetic Counselling + BRCA 1/2 analysis</b> (for LL Genetics) - \$600 TAT: 4-6 weeks <input type="checkbox"/> <b>Expedited Genetic Counselling + BRCA 1/2 analysis</b> (for LL Genetics) - \$850 TAT: 2-3 weeks					<b>ON-LL TR#</b>		<b>Mnemonic</b>										
					5501												
					5520												
<b>Date Sample Collected</b>		M	M	D	D	Y	Y	Y	Y	<b>Time Collected</b>		H	H	M	M	<b>Collector Name:</b>	
<p><b>GENETIC TESTING CONSENT</b></p> <p>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.</p> <ol style="list-style-type: none"> <li>I understand that once the requested test(s) has/have been completed, any remaining sample will be stored at the testing laboratory.</li> <li>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.</li> </ol> <input type="checkbox"/> 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.																	
<p><b>Patient/Substitute Decision Maker: Signature:</b> _____ ; <b>Date:</b> _____</p> <p><b>Printed name:</b> _____ ; <b>Relationship to person being tested:</b> _____</p> <p><b>OR: I certify that verbal consent was obtained from the patient / substitute decision maker for the requested genetic testing</b></p> <p><b>Signature of Physician :</b> _____ ; <b>Date:</b> _____</p>																	

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

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

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