HEREDITARY CANCER GENETIC TESTING & COUNSELLING REQUISITION

Appointment Booking: www.lifelabs.com

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

CONTRACT #		**Clear Form**
Ordering Physician #	Physician OHIP# (Ontario): Physician MSC# (British Columbia): Other Provinces (Ontario Voyager): 999	**LifeLabs Demographic Label**
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:**	**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 TC#**	**Mnemonic**
❑ **Genetic Counselling + BRCA 1 & 2 analysis** (for LL Genetics) - **$600** *TAT: 4-6 weeks*	**5501**	**BRCALL**
❑ **Genetic Counselling + Hereditary Cancer Panel analysis** (for LL Genetics) - **$729** *TAT: 4-6 weeks* *Genes covered: APC, ATM, AXIN2, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, CTNNA1, DICER1, EPCAM, GREM1, HOXB13, KIT, MEN1, MLH1, MSH2, MSH3, MSH6, MUTYH, NBN, NF1, NTHL1, PALB2, PDGFRA, PMS2, POLD1, POLE, PTEN, RAD50, RAD51C, RAD51D, SMAD4, SMARCA4, STK11, TP53, TSC1, TSC2, VHL*	**HCP**	**HCP**

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 Invitae have entered into a mutually binding distribution agreement whereby both organizations will comply with all applicable legislation. Invitae complies with U.S.A. 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 Invitae at their laboratory in the U.S.A. (1400 16th Street, San Francisco, CA 94103). To ensure accurate testing, I agree that the results of genetic testing that I have had previously completed by Invitae 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 Invitae, 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.

Pre and post test counselling is included as part of the BRCA1&2 and hereditary cancer panel testing. A member of our genetics team will contact you to book these appointments. We strongly recommend the counselling sessions to ensure appropriate risk assessment, and understanding of the benefits and limitations of the test, results and follow-up.

❑ I decline pre-test counselling.

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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Test methodology:	☒ FULL ANALYSIS – *sequencing and deletion/duplication* ❑ Familial Mutation (*Familial Report attached* **Y/N**) *Gene:*_____ *Mutation (HGVS)*:_____
Sample Type:	❑ **Blood** (EDTA: 8- 10mL) ❑ **Saliva** (Oragene OG-510, available by request)
Patient Ancestry:	❑ Ashkenazi Jewish ❑ Asian ❑ Black/African ❑ French Canadian ❑ Hispanic ❑ Mediterranean ❑ Indigenous ❑ Pacific Islander ❑ Sephardic Jewish ❑ White/Caucasian ❑ Other – *please specify:* _____
Reason for Testing:	☐ **Personal history of cancer ☐ **Family history of cancer ☐ **Known familial mutation ☐ Personal Choice ☐ Other: ***Please fill in additional details in Clinical Information below*
Clinical Information:	**Additional patient medical information:** **Relevant family history:**
Additional Family Members:	**Have other family members submitted samples to LifeLabs for analysis?** ❑Y ❑ N If yes, Name:_____ Relationship to patient _____ D.O.B. *(MM/DD/ YYYY)*:_____

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