LCA Use Only.
Please place accessioning sticker here.

Clinical Questionnaire for **Hereditary Cancer**

Prior authorization questions, call 866-248-1265. / Fax 855-711-5699 / Test questions, call 800-345-4363.

Name and title of person completing this form _____

Test Information (THIS IS NOT AN ORDER FOR A TEST)

Note: For Medicare recipients, a signed ABN must accompany the sample if an ICD-10 Code that supports medical necessity is not provided.

ICD-10 Diagnosis Code(s) Required							

BRCA*ssure*® Test Options	**Test No.**
◯ *BRCA1/2* Comprehensive Analysis	**485030**
◯ *BRCA1/2* Ashkenazi Jewish Profile	**485097**
◯ *BRCA1/2* Deletion/Duplication Analysis	**485050**
◯ *BRCA1* Targeted Analysis*	**485066**
◯ *BRCA2* Targeted Analysis*	**485081**

**A copy of the positive family member's laboratory report documenting the variant is required for this testing.*

VistaSeq® Test Options	**Test No.**	**VistaSeq® Test Options**	**Test No.**
◯ Comprehensive - 27 Genes	**481220**	◯ Colorectal - 7 Genes	**481352**
◯ Comprehensive w/o *BRCA* - 25 Genes	**481240**	◯ Colorectal - 22 Genes	**481363**
◯ Breast - 19 Genes	**481319**	◯ Pancreatic - 14 Genes	**481385**
◯ Breast - 9 Genes	**481452**	◯ Endocrine - 13 Genes	**481374**
◯ Breast & Gyn - 25 Genes	**481341**	◯ Renal - 19 Genes	**481407**
◯ Gyn - 11 Genes	**481330**	◯ Brain/CNS/PNS - 17 Genes	**481386**

Visit www.labcorp.com for detailed information on genes included in each panel

Patient Demographics

Patient's name _____ / Date of birth_____ / Gender: ◯ Male ◯ Female

Patient's Phone No. _____ / Patient's Email _____

Patient History (check all that apply)

◯ **Genetic counseling performed, if marked, attach report** **Performed by** _____ **Phone** _____

◯ **Patient had previous hereditary cancer testing, if marked, attach report**

◯ **History of bone marrow/stem cell transplant** / ◯ **History of blood transfusion**, date of last transfusion _____

◯ **No personal history of cancer**

◯ **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 _____

◯ **Renal cancer,** age at Dx _____

◯ **Colorectal cancer,** age at Dx _____

MSI Results: ❑ High ❑ Low ❑ Stable **IHC Results:** If present, specify results _____

◯ **History of colon polyps,** age at Dx _____ , Number _____

◯ **Pancreatic cancer,** age at Dx _____

◯ **Prostate cancer,** age at Dx _____, Gleason Score _____, ❑ Metastatic

◯ **Other cancer** _____, age at Dx _____

Family History (attach additional pages if needed)

Does the patient have Ashkenazi Jewish ancestry? ◯ No ◯ Yes

◯ Unknown or limited family history? Please explain (eg, adopted) _____

Relative*	**Maternal / Paternal**	**Cancer Type**	**Relative Available for Testing?** If no, state reason.	**Age At Diagnosis**	**Known Mutation?** If yes, attach lab report.
	❑ / ❑		❑ Yes ❑ No		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No		❑ Yes ❑ No

Ordering provider understands by signing below:
Pretest counseling, which includes an interpretation of family and medical histories; education about inheritance, genetic testing, disease management, prevention, and resources; counseling to promote informed choices and adaptation to the risk or presence of a genetic condition; and counseling for the psychological aspects of genetic testing, has been completed where required by health plan. Post-test counseling will be available.

Account No.: _____

Provider Name (print): _____ NPI: _____

Provider Phone No.: _____ Fax No.: _____

_____ / _____
Ordering Provider Signature **Date**

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 prior authorization with my health plan as required. I understand a prior authorization approval from my health plan does not guarantee full payment. LabCorp will attempt to contact me if my estimated out-of-pocket cost is more than $300. Testing may be canceled if LabCorp is unable to reach me. No matter my estimated cost, my actual out-of-pocket cost may be higher or lower than the estimate provided. It is my responsibility to contact my health plan regarding concerns over my coverage and benefits.

◯ **If marked, in the event I cannot be reached, LabCorp may leave a confidential voicemail message at the telephone number provided on this form.**

_____ / _____
Patient Signature **Date**

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LabCorp Specialty Testing Group

*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).

TIN: 13-3757370 / NPI: 1750368700

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Reset Form