



A DIVISION OF

**GENESIS**  
CLINICAL  
DIAGNOSTICS

A MEMBER OF GENESIS BIOTECHNOLOGY GROUP

### MEDICAL DIAGNOSTIC LABORATORIES

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## Variant of Uncertain Significance (VUS) Test Requisition Form

### Ordering Physician/Laboratory

(Required: Include the ordering physician's first & last name, NPI, practice name, complete address, phone number and fax number.)

Physician to receive additional result report:

Physician's Signature:

Date:

### Patient Information (Please Print)

Name (Last, First) (Required):

In Care of:

Patient Address:

City:

State:

Zip:

Assigned Sex at Birth (Required):

Female  Male

Date of Birth (Required):

Patient ID#:

Phone Number:

Cell Phone  
 Home Phone

Race:  Alaska Native or American Indian  Asian  Black or African American  Multiracial  Native Hawaiian or other Pacific Islander  Other race  White  Does not wish to disclose  Not provided

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown

Gender Identity:  Male  Female  Gender nonconforming  Transgender male-to-female  Transgender female-to-male  Does not wish to disclose  Not provided

Sexual Orientation:  Bisexual  Straight  Gay or Lesbian  Something else  Does not wish to disclose  Not provided

### Billing Information (Please include a copy of the front & back of card.)

Billing Type:  Patient  Insurance  Client **Relation (Required):**  Self  Spouse  Dependent

Insured's Name (if not patient):

Insured's SS#:

Insured's DOB:

Primary Insurance Carrier:

Medicare, Medicaid or Policy ID#:

Claims Address:

Employer/Group Name:

Group#:

### Genetic Testing Specimen Information

Date Collected (Req.):

Specimen Source:

Blood

Saliva

### Test Selection - Blood or Saliva

ICD10 codes (Req.):

1224 Gene Specific Site Analysis:

Specify Gene: \_\_\_\_\_

Variant (mutation): \_\_\_\_\_

### Information from Family Member's Previous Testing:

Please attach the original family member's clinical report or provide the MDL# and information below:

Family Member MDL #: \_\_\_\_\_

Relationship to Family Member: \_\_\_\_\_

Gene(s): \_\_\_\_\_

Variant(s): \_\_\_\_\_

### Confirmation of Consent for Genetic Testing

My signature below certifies that I have read and fully understand this test requisition form and acknowledge that I consent to testing for MDL's VUS Resolution Program. I understand that this is a voluntary program with no additional charge for selected family members of patients previously tested by MDL. Participation in this program may not result in an immediate reclassification and interpretation of the VUS variant to be tested. However, reclassification can still occur at a later date after multiple families with the variant are tested. Not all variants can be resolved through this program. I understand that if a variant is reclassified, an amended report with the new interpretation will be reported to me only and not to any health-care provider or any other third-party.

Patient Signature (Required)

Date

### Clinical Information

(Necessary for accurate test interpretation of BRCA Testing)

Race/ Ethnicity:  African American/Black  Asian  Jewish (Ashkenazi)  Other:  Caucasian  Hispanic  Native American

#### Patient Previous Genetic Testing:

No history of Genetic Testing Positive test:  BRCA1  BRCA2 Negative test:  BRCA1  BRCA2

#### Family History:

Is there a known family history of BRCA genes mutations? (Please include a copy of the family mutation report.)  No family history Yes:  BRCA1  BRCA2

Is there any cancer in the family history?  No family history  Yes: (please, specify below)

Family Cancer Site	Age at Dx	Relationship	Maternal	Paternal
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

#### Personal Patient History:

Is there any cancer in the personal history?  No history of cancer  Yes: (please, specify below)

Personal Cancer Site	Age at Dx	Comments/Details
Breast: <input type="checkbox"/> IDC (invasive ductal carcinoma) <input type="checkbox"/> ILC (invasive lobular carcinoma) <input type="checkbox"/> DCIS (ductal carcinoma <i>in situ</i> ) <input type="checkbox"/> LCIS (lobular carcinoma <i>in situ</i> )	_____	<input type="checkbox"/> Bilateral <input type="checkbox"/> Premenopausal ER (+) <input type="checkbox"/> (-) <input type="checkbox"/> PR (+) <input type="checkbox"/> (-) <input type="checkbox"/> HER2/neu (+) <input type="checkbox"/> (-) <input type="checkbox"/>
Ovarian <input type="checkbox"/>	_____	
Pancreatic <input type="checkbox"/>	_____	
Prostate <input type="checkbox"/>	_____	Gleason Score: 2 3 4 5 6 7 8 9 10

Other (specify):

Bone marrow transplant recipient?  Yes  No  
Current diagnosis of hematological cancer?  Yes  No  
Currently receiving radiation therapy/chemotherapy?  Yes  No

**Clinical Information (Required for Long QT Syndrome Testing)**

History of Cardiac Disease	Age at Dx	Relationship	Maternal	Paternal
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

Has known familial mutation testing been previously performed?  No  Yes (Please include a copy of the family mutation report.)

If yes, please indicate:



Gene: \_\_\_\_\_ Mutation: \_\_\_\_\_ Name of Proband: \_\_\_\_\_ Relationship to Proband: \_\_\_\_\_

**Clinical Information (check all that apply):**

- No personal history of cardiovascular disease.
- Syncope - If yes, provide # episodes: \_\_\_\_\_ Age of first incident: \_\_\_\_\_
- Palpitations.
- Congenital hearing loss.
- Cardiac arrest - If yes, provide # episodes: \_\_\_\_\_ Age of first incident: \_\_\_\_\_
- History of cardiomyopathy - If yes, provide # episodes: \_\_\_\_\_ Age of first incident: \_\_\_\_\_
- Wolff-Parkinson-White syndrome (WPW).
- Prolonged QT interval - If yes, provide interval: \_\_\_\_\_ msec
- AV block.
- Ventricular arrhythmias.
- Atrial fibrillation.
- Short QT interval.
- Rugada syndrome.
- Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)
- Other arrhythmia types: \_\_\_\_\_
- Additional EKG findings: \_\_\_\_\_
- Cardiomyopathy:
  - Hypertrophic cardiomyopathy (HCM)  Restrictive cardiomyopathy (RCM)  Dilated cardiomyopathy (DCM)
  - Left Ventricular Non-Compaction cardiomyopathy (LVNC)  Other (specify): \_\_\_\_\_
- Cardiovascular Device implantations - If yes:
  - Pacemaker (PCM) - If yes, age at implantation: \_\_\_\_\_  Stent  Other (specify): \_\_\_\_\_
- Hyperlipidemia.
- Previous angioplasty.
- History of deep-vein or pulmonary thrombosis.
- Additional/Other History including any previous genetic testing (attaching report is preferred):

**Medical Necessity Guidelines:**

Physicians must only order tests that they have determined are medically necessary for the diagnosis and treatment of a patient. MDL offers individual tests, as well as a limited number of customized panels. MDL provides practitioners with the flexibility to choose appropriate individual tests for each specimen to assure that the convenience of ordering panels does not impede them from ordering tests/panels that are medically necessary. All tests listed in panels may be ordered individually using this test requisition form. If you choose to order a panel, please make certain that each and every test is medically necessary. If you check off a panel as your choice, MDL understands that the physician has determined that all of the component tests are medically necessary, and will perform, report and bill for all such component tests.

Specimen Collection Platform		TAT	Stability	Test Additions*	Specimen Collection
Whole Blood	 Yellow Top Tube (ACD Solution A)	3-5 days	48 hours	30 days to add tests	1. In accordance with the standard operating procedure of your facility, collect blood in two yellow top (ACD solution A) tubes. 2. Allow the tubes to fill properly to ensure the proper blood to anticoagulant ratio. 3. Invert gently several times to mix and prevent clot formation. Do not shake the tubes. Do not centrifuge.
Saliva		5 - 10 days	48 hours	30 days to add tests	<ul style="list-style-type: none"> <li>• <b>Vigorously rinse mouth with clean water 5 minutes prior to specimen collection (30 minutes prior is ideal).</b></li> <li>• <b>After rinsing, do not brush teeth, use mouthwash, eat, drink, chew gum or smoke prior to sample collection.</b></li> </ul> 1. Begin collecting your sample by allowing saliva to pool in your mouth. Then spit into the wide funnel of the tube allowing saliva to collect in the upper chamber of the tube. Fill the tube until the amount of saliva (not bubbles) reaches the fill line as shown. 2. Once filled, unscrew the funnel allowing the saliva to flow into the lower chamber of the tube containing the stabilizing solution. Discard the funnel. 3. Use the blue cap to close the tube tightly. Shake the capped tube for 5 seconds.

\*Pending QC review for sufficient specimen volume