

STAT Date of surgery: ___/___/___ email: hcbranford@sema4genomics.com
Please note that the STAT process will bypass insurance preauthorization and may result in unexpected out of pocket costs.

PATIENT INFORMATION

Last Name		First Name		MI
Date of Birth	/	/	Biological Gender	M F
Telephone				
Address				
City / State / Zip				
Email				

Ethnicity (Check all that apply)
 African American Asian Caucasian Hispanic Jewish (Ashkenazi) Portuguese
 Other: _____

BILLING INFORMATION Institutional Bill

POLICYHOLDER LAST NAME	POLICYHOLDER FIRST NAME	POLICYHOLDER DOB
INSURANCE CARRIER	INSURANCE ID	GROUP NO.
BILLING ADDRESS		
OTHER HEALTH COVERAGE (IDENTIFY)	SELF-PAY: <input type="checkbox"/> Credit Card <input type="checkbox"/> Check	

Pre-Authorization #: _____ Please include a copy of all insurance paperwork.

Make Checks Payable to:
Mount Sinai Genomics Inc., P.O. Box 21312, New York, NY 10087-1312

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the provider and I understand that I am financially responsible for uncovered services. I also authorize the release of any information required to process the claim. Billing inquiries, please call 800-298-6470, Option 3.

SIGNATURE _____ DATE ___/___/___

REFERRING PROVIDER INFORMATION

MEDICAL PROVIDER SIGNATURE OF CONSENT REQUIRED BELOW: I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested. I have answered this person's questions. I have obtained informed consent from the patient or their legal guardian for this testing.

SIGNATURE _____ DATE (MM/DD/YY) ___/___/___

INDICATIONS FOR TESTING

PATIENT CLINICAL HISTORY: None Yes (turn form over)

PATIENT TESTING HISTORY: None Yes (turn form over)

FAMILY HISTORY: None Yes (turn form over)

ICD10 Dx CODE(S) - REQUIRED

- | | |
|--|--|
| <input type="checkbox"/> C61 - Malignant Neoplasm of Prostate | <input type="checkbox"/> Z85.07 - Personal history of malignant neoplasm of pancreas |
| <input type="checkbox"/> Z85.3 - Personal history of malignant neoplasm of breast | <input type="checkbox"/> Z85.46 - Personal history of malignant neoplasm of prostate |
| <input type="checkbox"/> Z85.43 - Personal history of malignant neoplasm of ovary | <input type="checkbox"/> Z80.42 - Family history of malignant neoplasm of prostate |
| <input type="checkbox"/> Z80.3 - Family history of malignant neoplasm of breast | <input type="checkbox"/> Z80.42 - Family history of malignant neoplasm of prostate |
| <input type="checkbox"/> Z80.41 - Family history of malignant neoplasm of ovary | <input type="checkbox"/> Z80.8 - Family history of malignant neoplasm of other organ |
| <input type="checkbox"/> Z80.0 - Family history of malignant neoplasm of digestive organs | <input type="checkbox"/> Z85.00 - Personal history of malignant neoplasm of unspecified digestive organ |
| <input type="checkbox"/> Z85.00 - Personal history of malignant neoplasm of unspecified digestive organ | <input type="checkbox"/> Other: _____ |

COLLECTION DATE: ___/___/___

OF BLOOD TUBES SENT: YELLOW _____ PURPLE _____ GREEN _____ SALIVA _____

LABORATORY TEST(S) ORDERED - SEE REVERSE FOR FULL GENE LISTING

Genetic counseling provided by GeneScreen

Comprehensive Hereditary Cancer

- CancerNext sequencing and deletion/duplication testing
 CancerNext-Expanded sequencing and deletion/duplication testing

Hereditary Breast and Ovarian Cancer

- BRCA 1 and BRCA 2 sequencing and deletion/duplication testing
 BRCA Ashkenazi Jewish 3-site mutation panel
 BRCAplus sequencing and deletion/duplication testing
 BreastNext sequencing and deletion/duplication testing
 GYNplus sequencing and deletion/duplication testing
 OvaNext sequencing and deletion/duplication testing

Hereditary Colon Cancer

- Lynch/HNPCC Sequential (Step1: MLH1, MSH2, and MSH6 sequencing and deletion/duplication testing + EPCAM deletion/duplication testing. Step2: PMS2 sequencing and deletion/duplication testing)
 Lynch/HNPCC Concurrent (MLH1, MSH2, MSH6 and PMS2 sequencing and deletion/duplication testing + EPCAM deletion/duplication testing)
 MSH2 Inversion
 ColoNext sequencing and deletion/duplication testing

Hereditary Brain Tumors/Cancers

- BrainTumorNext sequencing and deletion/duplication testing

Hereditary Melanoma

- MelanomaNext sequencing and deletion/duplication testing

Hereditary Pancreatic Cancer

- PancNext sequencing and deletion/duplication testing

Hereditary Prostate Cancer

- ProstateNext sequencing and deletion/duplication testing

Hereditary Paragangliomas and/or Pheochromocytomas

- PGLNext sequencing and deletion/duplication testing

Hereditary Renal Cancer

- RenalNext sequencing and deletion/duplication testing

Single site/Single gene analysis:

Gene _____, Variant (if applicable) _____

(Please attach a copy of the relative's test report)

Relationship to relative _____

- Reflex testing request:

Lab Use Only

TEMP	SPECIMEN	# OF SPEC	TEMP	SPECIMEN	# OF SPEC	DATE SPECIMEN RECEIVED	INITIALS
Am Ref Fz			Am Ref Fz			/ /	

Client Bill Institutional Bill

PATIENT CLINICAL HISTORY

Please include a copy of medical consult notes, if available, for billing investigation purposes.

No personal history of cancer

Table with columns: Cancer/Tumor, Age at Dx, Pathology and Other info. Rows include Brain tumor, Breast, 2nd primary breast, Colorectal, Melanoma, Ovarian, Pancreatic, Prostate, Uterine, Hematologic, Other Cancer, and GI Polyps.

Other clinical history:

PATIENT TESTING HISTORY (IF APPLICABLE) NO PREVIOUS GENETIC TESTING

Form fields for genetic testing history including Germline genetic testing, Somatic test/tumor profile, Microsatellite instability analysis, and IHC.

FAMILY HISTORY

THERE IS A KNOWN VARIANT IDENTIFIED IN THE FAMILY. GENE: _____ VARIANT: _____ (please attach report)

Table for family history with columns for Maternal, Paternal, and Other family history of cancer, including relation to patient, H/o cancer/polyps, and Dx age.

Hereditary Breast and Ovarian Cancer

BRCA1 and BRCA2 sequencing and deletion/duplication testing
BRCA Ashkenazi Jewish 3-site mutation panel
BRCAplus (sequencing and deletion/duplication testing of the following 8 genes):
BreastNext (sequencing and deletion/duplication testing of the following 17 genes):
GYNplus (sequencing and deletion/duplication testing of the following 13 genes):
OvaNext (sequencing and deletion/duplication testing of the following 25 genes):

Hereditary Brain Tumors/Cancers

BrainTumorNext sequencing and deletion/duplication testing
AIP, ALK, APC, CDKN1B, CDKN2A, DICER1, MEN1, MLH1, MSH2, MSH6, NBN, NF1, NF2, PHOX2B, PMS2, POT1, PRKAR1A, PTCH1, PTEN, SMARCA4, SMARCB1, SMARCE1, SUFU, TP53, TSC1, TSC2, VHL

Hereditary Melanoma

MelanomaNext (sequencing and deletion/duplication testing of the following 8 genes):
BAP1, BRCA2, CDK4, CDKN2A, MITF, PTEN, RB1, TP53

Hereditary Pancreatic Cancer

PancNext (sequencing and deletion/duplication testing of the following 13 genes):
APC, ATM, BRCA1, BRCA2, CDKN2A, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53

Hereditary Prostate Cancer

ProstateNext (sequencing and deletion/duplication testing of the following 14 genes):
ATM, BRCA1, BRCA2, CHEK2, EPCAM, HOXB13, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, RAD51D, TP53

Hereditary Paragangliomas and/or Pheochromocytomas

PGLNext (sequencing and deletion/duplication testing of the following 12 genes):
FH, MAX, MEN1, NF1, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL

Hereditary Renal Cancer

RenalNext (sequencing and deletion/duplication testing of the following 19 genes):
BAP1, EPCAM, FH, FLCN, MET, MITF (genotyping for c.952G>A ONLY), MLH1, MSH2, MSH6, PMS2, PTEN, SDHA, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL

Hereditary Colon Cancer

Lynch/HNPCC Sequential
Lynch/HNPCC Concurrent
ColoNext (sequencing and deletion/duplication testing of the following 17 genes):
APC, BMPR1A, CDH1, CHEK2, EPCAM, GREM1, MLH1, MSH2, MSH6, MUTYH, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53

Comprehensive Hereditary Cancer

CancerNext (sequencing and deletion/duplication testing of the following 34 genes associated with increased risk for breast, ovarian, colorectal, uterine, and other cancers):
CancerNext-Expanded (sequencing and deletion/duplication testing of the following 67 genes associated with increased risk for breast, colon, ovarian, pancreatic, renal, uterine, and many other cancers):

* = sequencing is not available for this gene, (deletion/duplication testing ONLY)

Informed Consent for Hereditary Cancer Genetic Testing

I, _____, hereby request genetic testing for

Myself

My child _____

I have received verbal and written information (please see sema4.com/testcatalog for test-specific information sheet) from my physician or from a genetic counselor that described, in words that I understood, the nature of the genetic testing that I/my child am about to undergo.

The nature of the genetic test, _____, has been explained to me and the accuracy of the test and its risks and limitations have been detailed. I understand that specimen(s), such as peripheral blood, saliva, cheek swab, or skin biopsy will be taken from me/my child. I understand that the samples will be used for determining if I have /my child has a genetic disease, are carriers of a genetic disease or are more susceptible to develop a genetic disease or medical condition. The results may also suggest that I am affected with condition that is different than, and/or that is in addition to, those considered for the purpose of consenting for this test. I further understand that my or my child's genetic test results may have implications for the rest of the family as genetic changes can be inherited.

No test will be performed and reported on my sample other than the one(s) authorized by my doctor. I understand that there are several types of genetic test results, including:

- **Positive**, meaning that a mutation that is associated with an increased risk to develop cancer has been identified. The specific type(s) of these risks can vary depending on the gene in which the mutation is found. A positive result may have medical management implications. For certain genes/mutations, the cancer risks are not well established at this time, and more data and specific medical management recommendations related to these genes may evolve over time.
- **Negative**, meaning that no mutations were identified. A negative result reduces, but does not eliminate, the possibility that I carry /my child carries mutations in the genes analyzed or in other genes that are not included in the test. I/my child still have the general population's risk for developing cancer and may also be at a higher risk to develop cancer based on personal/family history.
- **Inconclusive**, meaning that an alteration was identified in the genes tested where there is insufficient information at this time to determine if such alteration is associated with increased cancer risks.

I will discuss any appropriate medical intervention with my healthcare provider before taking any action based on my/my child's results, and I will provide my/my child's genetic test result and personal/family history to my healthcare providers so that they can make an appropriate recommendation.

I understand that although the likelihood of an incorrect diagnosis or a misinterpretation of the result is extremely small, infrequent errors may occur. I understand that this testing may yield results that are of unknown clinical significance and that parental and/or other relative's specimens may also be tested or requested to determine whether a specific finding is inherited. In addition, incidental findings that are not related to the primary diagnosis may be identified in me/my child. An error in the diagnosis may occur if the true biological relationships of the family members involved in this study are not as I have stated.

There are some federal and state laws that address genetic discrimination. The US Genetic Information Nondiscrimination Act (GINA) may prohibit discrimination by employers and health insurances. This law, however, does not protect people in the military nor possible discrimination by other types of insurance such as life, disability or long-term care.

De-identified research

Sema4 may also give the de-identified information to its research partners and may submit this de-identified information to research databases for use in scientific and medical research, including scientific databases that are maintained by the federal government, such as a database kept by the National Institutes of Health ("NIH") (an agency of the federal government that funds research). Researchers have to apply to the NIH to see the information in the database. Any information that could directly identify you (such your name or address) will not be provided to a scientific database.

If I prefer not to have any of my/my child's de-identified health information used in research consistent with this consent, I may initial here _____ or request this by contacting Sema4, including by emailing privacy@sema4.com.

Permission to contact

I understand that Sema4 may wish to contact me/my child in the future, including for the following reasons: research purposes, the provision of general information about research findings, and/or the provision of information about the results of tests on my/my child's sample(s). I understand that I may notify Sema4 to opt out of such future contact, including by emailing privacy@sema4.com.

The results of my/or my child's test will be explained to me by a genetic counselor or by my physician who will have the opportunity to discuss my results with a geneticist. I have had the opportunity to have all of my questions answered. If I am signing this form on behalf of a minor for whom I am the legal guardian, I am satisfied that I have received enough information to sign on his or her behalf.

I understand that this consent is being obtained in order to protect my right to have all of my questions answered before testing. I understand that the results of this testing will become part of my medical record and may only be disclosed to individuals who have legal access to this record or to individuals who I designate to receive this information.

Sample storage

By initialing here, I agree that Sema4 may store, de-identify, and use my/my child's sample and information to support medical and academic research relating to health, disease prevention, drug development, and other scientific purposes, and that I/my child will receive no compensation in connection with such research. If I do not initial here, my/my child's sample will be destroyed at the end of the testing process or not more than 60 days after collection. I understand that I may withdraw this consent by contacting Sema4 (including by emailing privacy@sema4.com).

Initials

Signature of person being tested (or guardian)

Date