



Patient Name

Date of Birth

Affix barcode label of Patient's sample here

Required Information Checklist:

- ICD-10 codes
- Healthcare provider signature
- Completed TRF and all clinical notes faxed to 617-433-5024
- Clinical & genetic counseling notes with pedigree (please include all known family members with cancer and copies of genetic test results if available)
- Letter of medical necessity and/or required insurance forms, if applicable

Clinical Information

ICD-10 Code(s)*

Suspected Diagnosis

Has the patient been diagnosed with cancer? Yes / No
 Age of diagnosis:
 Specify cancer type if applicable:

Has the patient had previous hereditary cancer genetic testing? Yes / No

***If available please include copies of the reports.**

Testing Options: (check box)

OncoAlly™ Comprehensive Hereditary Cancer Analysis (OA011)

OncoAlly™ Colorectal Cancer Analysis (OA013)

OncoAlly™ Common Hereditary Cancer Analysis (OA012)

OncoAlly™ BRCA1/2 Analysis (OA014)

Healthcare Provider's Statement

By my signature below, I attest that I am the referring physician, an authorized healthcare provider for the patient or procurator thereof, and this testing is medically necessary for diagnosis and/or treatment of the patient. I attest that the patient or guardian has voluntarily consented to genetic testing for diagnostic purposes, including possible results and outcomes, has been given the opportunity to ask questions about the testing and/or seek genetic counseling, and agrees to allow an independent genetic counselor facilitated through a third party to provide pre-test and/or post-test genetic counseling if required by the insurer and/or referring institution.

Healthcare provider signature _____

Date _____

Patient Information

First Name

Last Name

MI

DOB

Genetic Sex

Male Female Other _____

Address

ID / MR#

Gender identification (optional): _____

City

State

Zip Code

Phone

Email

Other Name (if different than listed above):

Pronouns

Preferred language

Please use this name in communications.

English

Spanish

Ordering Healthcare Provider

First Name

Last Name

NPI #

Facility Name

Phone

Facility Address

Fax

City

State

Zip Code

Email

Additional Report Recipients

Name

Phone

Fax

Email

Name

Phone

Fax

Email



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Billing Information

Insurance Billing

Insurance Company	Policy #	Group #
Policy Holder First Name	Policy Holder Last Name	Policy Holder DOB
Policy Holder Address	Who is the Policy Holder? <input type="radio"/> Patient <input type="radio"/> Spouse <input type="radio"/> Parent	
Employer's Address		

Institutional Billing

An invoice will be sent to the institution listed above. Please contact us for alternate billing.	<input type="radio"/> Patient Payment
Who should be contacted for billing purposes? An invoice will be sent to the patient email provided. Insurance will not be billed.	
Contact person (billing):	Payer Name:
Payer Phone:	Payer Phone:
Payer Email:	Payer Email:

Patient Sample Information

Sample Type <input type="radio"/> Saliva* <input type="radio"/> Saliva swab*† <input type="radio"/> Genomic DNA <input type="radio"/> Assisted saliva* <input type="radio"/> Blood <input type="radio"/> Other: <small>* Use Variantyx collection kits only</small> <small>† Saliva swab is similar to a buccal swab; Saliva swabs may have reduced sensitivity and specificity due to the presence of normal oral flora</small>	Sample Will Be Collected <input type="radio"/> In-clinic <input type="radio"/> Patient was given kit <input type="radio"/> Coordinated by Variantyx	Collection date
Please check if your patient has had a: <input type="radio"/> Blood transfusion within the last two weeks <input type="radio"/> Bone marrow transplant <i>We will contact you for additional specimen collection details.</i>		