Variantyx

OncoAlly®
Hereditary Cancer Testing
Test Requisition Form
Page 1 of 2

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 aplicable:	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)
◯ Opt in for Genomic Unity® Pharmacogenomics Analysis	**No selection will default to opt-out.*

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, pharmacogenomics analysis, if selected, 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): ◯ Please use this name in communications.	Pronouns	Preferred language ◯ 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? ◯ Patient ◯ Spouse ◯ Parent	
Employer's Address		

◯ Institutional Billing	◯ Patient Payment
An invoice will be sent to the institution listed above. Please contact us for alternate billing.	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	Sample Will Be Collected	Collection date
◯ Saliva* ◯ Saliva swab*† ◯ Genomic DNA ◯ Assisted saliva* ◯ Blood ◯ Other: * Use Variantyx collection kits only † Saliva swab is similar to a buccal swab; Saliva swabs may have reduced sensitivity and specificity due to the presence of normal oral flora	◯ In-clinic ◯ Patient was given kit ◯ Coordinated by Variantyx	

Please check if your patient has had a: ◯ Blood transfusion within the last two weeks ◯ Bone marrow transplant

We will contact you for additional specimen collection details.