

http://www.upmcgenomecenter.com
 Genome_Center@upmc.edu p : 412 623 7155
 5560 Centre Ave Pittsburgh | PA 15232
 Owatha L Tatum, PhD HCLD/CC(ABB) Director

ORDERING INSTITUTION INFORMATION

Institution Name		NPI #
Authorized Requester	Phone	Fax
Email		
Physician/Pathologist	Phone	Fax
Email		

PATIENT SAMPLE INFORMATION

Accession #	Hospital / Medical Record
Male Female Unknown	
Biological Sex:	Date of Birth (MM / DD / YYYY)
Gender Identity (if different from above):	Date of Collection (MM / DD / YYYY)
Blood in EDTA (Lavender top tube) Saliva Oragene iSwab TM	Buccal Swab Extracted DNA** Tissue (Source:)

Please ensure all samples follow Center Requirements, see Specimen Handling and Transportation below. For samples marked Other please contact before sending.

** NOTE: Extracted DNA/RNA will only be accepted if the isolation of nucleic acids for clinical testing occurs in a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by the CAP and/or the CMS.

RACE (check all that apply)

American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White

Has Patient had a bone marrow transplant/ transfusion: Yes No

Date of last transfusion: / / (2 weeks must pass before samples can be drawn for testing)

ADDITIONAL REPORT REQUEST

Email	Fax	Contact Role
Email	Fax	Contact Role

Patient Last Name	Patient First Name	MI
Address		Phone
City	State	Zip
		Yes No
Patient discharged from hospital/facility		

PHYSICIAN STATEMENT

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Authorized Requester is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Printed Name	Signature	Date (MM / DD / YYYY)
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INSURANCE AND BILLING INFORMATION

REQUIRED ITEMS: 1. Copy of the Front /Back of Insurance Card(s) 2. ICD10 Diagnosis Code(s) 3. Name of Ordering Physician (Above) 4. Insured Signature of Authorization (Above)
 DO NOT Complete Test Until Patient has confirmed Out Of Pocket Cost

Name of Insured	Insured Date of Birth	Name of Insured	Insured Date of Birth
Patient's Relationship to Insured	Phone of Insured	Patient's Relationship to Insured	Phone of Insured
Address of Insured		Address of Insured	
City	State	Zip	
Primary Insurance Co. Name	Primary Insurance Co. Phone	Secondary Insurance Co. Name	Secondary Insurance Co. Phone
Primary Member Policy #	Primary Member Group #	Secondary Member Policy #	Secondary Member Group #

PLACE BARCODED
PATIENT ID
LABEL HERE

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Genome_Center@upmc.edu p : 412 623 7155
5560 Centre Ave Pittsburgh | PA 15232
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SELF PAY Credit Card Check

Please make checks payable to UPMC Genome Center.

INSTITUTIONAL BILL

[Redacted]

Institution Name

[Redacted]

Institution Code

[Redacted]

Institution Contact Name

[Redacted]

Institution Phone

[Redacted]

Institution Contact Email

Please note that Medicare does not cover routine screening tests. I signed below hereby authorize UPMC to provide my insurance carrier any information necessary, including test results, for processing my insurance claim. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates, as well as many amounts not paid by my insurance carrier for reasons including, but not limited to, non-covered and non-authorized services. I understand that I am responsible for sending UPMC any and all payments that I receive directly from my insurance company in payment for this test.

[Redacted]

Patient's Printed Name

[Redacted]

Patient's Signature

[Redacted]

Date (MM / DD / YYYY)

CLINICAL INFORMATION

Please give a brief summary of the patient's clinical presentation and the reason for genetic testing, and ICD-10 code in the box provided below. Please also attach a three generation pedigree.

[Large empty box for clinical information and pedigree]

TEST SELECTION
STEP 1. PLEASE SELECT THE SEQUENCING METHOD FOR THE TESTS/PANELS OFFERED BELOW

WHOLE EXOME SEQUENCING (WES) GERMLINE PROBAND DUO TRIO

WHOLE GENOME SEQUENCING (WGS) GERMLINE PROBAND DUO TRIO

* For Duo/Trio sets, a separate requisition is required for each submitted sample.

STEP 2. PLEASE SELECT THE TESTS/PANELS
RARE-UNDIAGNOSED GENETIC DISEASE (RUGD)

HEREDITARY CANCER PANEL (*APC, ATM, AXIN2, BARD1, BAP1, BLM, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, DICER1, EPCAM, GREM1/SCG5, HOXB13, FH, FLCN, MEN1, MLH1, MSH2, MSH6, MRE11A, MUTYH, NBN, NF1, NTHL1, PALB2, PMS2, POLD1, POLE, PTEN, RAD50, RAD51C, RAD51D, SDHA, SDHB, SDHC, SDHD, SMAD4, SMARCA4, STK11, TP53, TSC1, TSC2, VHL, MET, MITF, POT1, RET, SDHAF2*)

BREAST AND GYNECOLOGIC CANCER PANEL (Breast, Ovarian, Uterine) (*ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, DICER1, EPCAM, MLH1, MSH2, MSH6, NBN, NF1, PALB2, PMS2, PTEN, RAD50, RAD51C, RAD51D, SMARCA4, STK11, TP53*)

GASTROINTESTINAL CANCER PANEL (Colorectal, Gastric, Pancreatic) (*APC, ATM, AXIN2, BMPR1A, BRCA1, BRCA2, CDH1, CDKN2A, CHEK2, EPCAM, GREM1, MEN1, MLH1, MSH2, MSH6, MUTYH, NF1, NTHL1, PALB2, PMS2, POLD1, POLE, PTEN, SDHA, SDHB, SDHC, SDHD, SMAD4, STK11, TP53, TSC1, TSC2, VHL*)

ENDOCRINE CANCER PANEL (Thyroid, Paraganglioma/Pheochromocytoma, Hyperparathyroidism) (*APC, CHEK2, DICER1, MEN1, NF1, PTEN, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TP53, VHL*)

GENITOURINARY CANCER PANEL (Renal/Urinary Tract, Prostate) (*ATM, BAP1, BRCA1, BRCA2, CHEK2, DICER1, EPCAM, FH, FLCN, HOXB13, MET, MLH1, MSH2, MSH6, NBN, PMS2, PTEN, SDHB, SDHC, SMARCA4, TP53, TSC1, TSC2, VHL*)

SKIN CANCER PANEL (Melanoma, Basal Cell Nevus Syndrome) (*BAP1, BRCA2, CDK4, CDKN2A, MITF, POT1, PTCH1, PTEN, TP53*)

BRAIN/NERVOUS SYSTEM CANCER PANEL (*APC, DICER1, EPCAM, MEN1, MLH1, MSH2, MSH6, NF1, PMS2, PTEN, SMARCA4, TP53, TSC1, TSC2, VHL*)

SARCOMA PANEL (*APC, BLM, DICER1, EPCAM, FH, MSH2, MSH6, NBN, NF1, PMS2, SDHA, SDHB, SDHC, SDHD, TP53*)

HEMATOLOGIC CANCER PANEL (Myelodysplastic Syndrome/Leukemia) (*ATM, BLM, BRCA2, BRIP1, EPCAM, MLH1, MSH2, MSH6, NBN, NF1, PALB2, PMS2, RAD51C, TP53*)

UGC 59 ACTIONABLE DISORDERS PANEL
Test Description:

UGC 59 Gene Actionable Disorders Panel analyzes the 59 genes identified as medically actionable by the American College of Medical Genetics and Genomics (ACMG ; Kalia *et al.*, 2017). These genes are medically actionable, with clinical management guidelines established for their associated conditions.

YES, I want my medically actionable 59 gene analysis reported by UGC.

NO, I do not want my medically actionable 59 gene analysis reported by UGC.

SPECIMEN HANDLING AND TRANSPORTATION:

Please label all containers with 2 unique identifiers (e.g., patient name, MRN, date of birth, date of collection etc). Use sterile technique and close all containers tightly. Samples should be delivered to the lab on the same day of collection unless otherwise stated below. If sample is collected after business hours or missed transportation pick-up, please keep sample in the refrigerator or at room temp and deliver to the lab as soon as possible on the next business day. Samples from off site should be shipped at room temperature for overnight delivery directly to the lab address listed below. In hot weather, a cool pack may be enclosed. **DO NOT FREEZE.**

Ship Specimens to: UPMC Genome Center, 5560 Centre Avenue Pittsburgh, PA 15232 Ph: 412 623 7155

Whole Blood	Minimum 2 mL of whole blood in EDTA (purple-top) tube. In case 2 mL can not be obtained, please contact us for instructions. If sample is not immediately shipped, it should be refrigerated at 2-8 °C. The samples should be received within 24 hours of collection and at ambient temperature. In hot weather a cool pack may be enclosed. Do not freeze whole blood.
DNA	Send the DNA specimen in a screw cap tube-at least 5 µg of genomic DNA at a concentration greater than 20 ng/µl. Ship overnight at room temperature. In hot weather a cool pack may be enclosed. Note: DNA must have been extracted in a CLIA-certified laboratory.
Saliva	Follow the instructions included in the kit to collect saliva sample. It can be stored at room temperature until shipped. Ship saliva specimens at ambient temperature within 2 weeks of collection.
Buccal Swab	Follow the instructions included in the kit to collect buccal brushes. It should be refrigerated at 2-8 °C until shipped. Ship buccal swab specimens at ambient temperature within 2 weeks of collection.