UPMC LIFE CHANGING MEDICINE

Patient Name:_____
Identification Number: _____

KNOWN FAMILIAL VARIANT GENETIC TESTING REQUISTION FORM

PATIENT INFORMATION (*Please Print*)			DIAGNOSIS CODING
First Name / MI		Last Name	ICD-10 Code(s)
DOB (mm/dd/yy)	MRN#	Sex M ☐ F ☐	
Address		Phone	Clinical Diagnosis
City	State	Zip Code	

Ancestry (check all that apply):

☐ White/Caucasian	☐ Asian	☐ Western/Northern Europe	☐ Native American
☐ Black/African American	☐ Ashkenazi Jewish	☐ Central/South American	☐ Other: (specify)
☐ Hispanic	☐ Eastern/Central Europe	☐ Middle Eastern	

REFERRING PROVIDER INFORMATION (*Please Print*)

Ordering Provider		NPI	Additional Provider		NPI
Address			Address		
City	State	Zip Code	City	State	Zip Code
Phone	Fax	Email	Phone	Fax	Email

SAMPLE INFORMATION

DATE OF SAMPLE OBTAINED (mm/dd/yy)	DOES YOUR PATIENT HAVE A?
☐ Blood in EDTA (3-5 ml in lavender or pink top tube)	☐ History of blood transfusion?
☐ Extracted DNA (Please contact PCGL prior to sending)	☐ History of hematological malignancy?
☐ Saliva kit	☐ History of allogenic bone marrow transplant?
☐ Cultured Fibroblasts	If the answer is yes to any of these questions, please contact the laboratory to discuss before sending a sample.

STATEMENT OF MEDICAL NECESSITY (*Required*)

I authorize and direct UPMC Pittsburgh Clinical Genomics Laboratory (PCGL) to perform the testing indicated. I confirm that the testing requested is reasonable and medically necessary and that the test results may impact medical management and treatment decisions for this patient. I certify that the patient or legal guardian has been informed of the risks, benefits and limitations of genetic testing. The person listed as the ordering provider is authorized by law to order the test(s) requested herein.

_____
Signature of Provider (required) Date

PATIENT CONSENT (*Required*)

By signing this form I acknowledge as the patient/legal guardian that I have read the attached informed consent document and that I authorize the UPMC PCGL to perform genetic testing as described.

_____
Print name of Patient/Legal guardian Signature of Patient/Legal guardian Date

PAYMENT OPTIONS (FILL OUT ONE OF THE OPTIONS BELOW)

☐ INSURANCE BILLING (copy front and back of insurance cards)

Primary Insurance	Insurance ID#	Name and DOB of Insured	Patient Relation to Policy Holder Self ☐ Spouse ☐ Child ☐
Secondary Insurance	Insurance ID#	Name and DOB of Insured	Prior Authorization # - Please Attach

☐ PATIENT BILLING

☐ I am electing to self-pay. I agree that neither UPMC Pittsburgh Clinical Genomics Laboratory (PCGL) nor I will submit a claim to my insurance for testing. Please discuss with your provider.

☐ INSTITUTIONAL BILLING

Facility	Address	Contact	Phone	Email

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REASON FOR TESTING

- ☐ Diagnosis/Affected
- ☐ Pre-symptomatic/At risk
- ☐ Carrier testing/unaffected
- ☐ Separate parental report (WES setting only)- free of charge

FAMILY MEMBER INFORMATION

Name of family member previously tested: _____
Date of birth of family member previously tested: _____
UPMC PCGL lab number of family member previously tested, if applicable: _____
Relationship to family member previously tested: _____

MEDICAL HISTORY

Is the patient symptomatic? If yes, please attach clinical note or provide medical history information.

_____
_____
_____
_____

FAMILY HISTORY

Attach pedigree or complete information below:

Relationship to patient	Maternal	Paternal	Medical history
	○	○	
	○	○	
	○	○	
	○	○	
	○	○	
	○	○	
	○	○	
	○	○	

SPECIAL INSTRUCTIONS

Family member previously tested at UPMC PCGL laboratory? Yes ____ No _____ If no, where _____

- ☐ Provide a specimen from the family member previously tested to serve as a positive control. The positive control specimen will be tested free of charge and no report will be provided. If a positive control is not provided, negative results will carry a limitation stating UPMC PCGL laboratory did not have the opportunity to verify that we can detect the variant in the family.
- ☐ Provide family member's test report. Please check one: Attached:_____ Send later_____

GENE INFORMATION

Sequence Variant information:

Gene _____ c. _____ p._____ Transcript (NM) _____
Gene _____ c. _____ p._____ Transcript (NM) _____
Gene _____ c. _____ p._____ Transcript (NM) _____
Gene _____ c. _____ p._____ Transcript (NM) _____

Copy Number Variant information:

Gene _____ Exon(s) _____ Coordinates _____ Genome Build _____
Gene _____ Exon(s) _____ Coordinates _____ Genome Build _____

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KNOWN FAMILIAL VARIANT GENETIC TESTING REQUISTION FORM

INFORMED CONSENT

GENETIC TESTING

The purpose of this test is to determine if there is a possible genetic reason for the patient's health condition. Finding a genetic cause may improve future medical care and treatment options and inform family planning.

Detailed medical and family history are needed for accurate interpretation of results. Clinical photographs can also be helpful.

Genetic counseling and/or clinical genetics consultation is recommended before and after genetic testing. Clinical reports are released only to the certified healthcare professional(s) listed on the order form. You may choose to request a copy of the clinical report from the healthcare professional who ordered the test.

FAMILY TESTING

Genetic testing may reveal that the true biological relationships in a family are not as they were reported. This includes non-paternity (the stated father of an individual is not the biological father) and consanguinity (the parents of an individual are related by blood). Incorrect information about the biological relationships in your family may result in incorrect interpretation of results, incorrect diagnoses, and/or inconclusive test results. If you have any concerns about any such issues, please discuss them confidentially with your genetic counselor or ordering provider.

POSSIBLE TEST RESULTS

The genetic variants found by whole exome sequencing will be classified according to the guidelines from the American College of Medical Genetics and Genomics (ACMGG). Three possible test results include:

- Positive: pathogenic or likely pathogenic variant) a variant was found that likely caused the patient's condition or carries an increased risk for developing the disorder in the future. This result may be important for other family members.
- Negative: no disease-causing variants were found. This result does not eliminate the possibility of a genetic condition not discovered by this test.
- Variant of uncertain clinical significance (VUS): A genetic variant was found, but it is currently unknown whether that change could have caused the patient's condition. A VUS may be benign or disease-causing, but more research is needed.

Because the literature, medical and scientific knowledge are constantly changing, new information that becomes available in the future may replace or add to the information UPMC Clinical Genomics laboratory used to interpret the results.

RISKS & LIMITATIONS

As with all laboratory testing, there is a small risk of getting an erroneous result.

DATA & UPDATED INFORMATION

Information about genetic disease is continually changing. Additionally, a patient's clinical presentation or family history may also change over time. It is the responsibility of the patient and ordering provider to be aware of any changes in the patient's symptoms and to communicate them to the laboratory. The laboratory will also re-contact the referring physician if the lab learns that new information about the gene(s) tested has been identified.

Sharing health history and genetic information can ultimately help health care providers deliver better care for their patients and provide researchers opportunities to make discoveries. UPMC submits de-identified information to public databases to contribute to the advancement of medical knowledge.

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INFORMED CONSENT continued

PRIVACY/PATIENT CONFIDENTIALITY

The United States Federal Government has enacted the Genetic Information and Non-discrimination Act (GINA) that prohibit discrimination, based on genetic test results, by health insurance companies and employers. These laws also prohibit unauthorized disclosure of this information. For more information you can visit https://www.eeoc.gov/laws/statutes/gina.cfm However, this law does not consider the possible impact these results may have on obtaining disability or life insurance.

Data and personal information will be stored and protected in strict confidence complying with regulatory requirements (e.g., HIPAA and equivalent protections), and I acknowledge that I have read and understand UPMC's privacy policy.

CANCELLATION OF TESTING

Request to cancel testing will be required within one business day of sample receipt. If the laboratory has already started the testing process, I will be responsible for the cost of the test. Written documentation of the request to stop testing will be required. My provider can contact the laboratory for the cancellation form.

INTERPRETER'S STATEMENT

Execute if an interpreter is provided to assist the individual in understanding this informed consent form:

I have translated the information and advice presented orally to the individual to be treated by the person obtaining this consent.

In addition, I have sight translated the consent form (read it aloud in his/her language). To the best of my knowledge and belief he/she understood this explanation.

_____
Cyracom ID (if applicable)

_____
Print Name

_____
Signature (Not required if a Cyracom Interpreter Was Used)