DYNIX DIAGNOSTICS

Dynix Diagnostix, Inc.
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Fort Pierce, FL 34946
Phone: 844-514-8158
Fax: 772-324-6330

Hereditary Cancer Test Requisition (Blue Sections Required)

INSURANCE ORDERING CHECKLIST
- ☐ Clinic Note(s) and Pedigree
- ☐ ICD-10 Code(s)
- ☐ Clinician & Patient Signatures
- ☐ Copy of Patient Insurance Card

PATIENT INFORMATION

Last Name	First Name	Middle Initial	DOB (MM/DD/YY)	Date of Death (if applicable)	Date of Discharge (if applicable)

Street Address	City	State/Country	Zip

Preferred Contact Phone Number	Biological Sex: ☐ F ☐ M Gender Identity (if different from marked): _____	Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Jewish (Ashkenazi) ☐ Portuguese ☐ Other: _____

SPECIMEN INFORMATION

Type(s) ☐ Buccal swabs			

SENDING FACILITY Facility Type: ☐ Physician/Physician Group ☐ Referral Lab ☐ Hospital

Facility Name (Facility Code)	Address	City	State /Country	Zip	Phone

ORDERING PHYSICIAN AND/OR OTHER LICENSED MEDICAL PROFESSIONAL

Name (Last, First, Degree) (Clinician Code)	Phone	Fax	Email	NPI#

ADDITIONAL RESULTS RECIPIENTS

☐ Primary Contact	Medical Professional Name (Clinician Code)	Phone	E-mail or Fax
☐ Primary Contact	Genetic Counselor Name (Clinician Code)	Phone	E-mail or Fax

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR GENETIC TESTING

By ordering testing, the undersigned person represents that he/she is a licensed medical professional authorized to order genetic testing OR is a representative of a licensed medical professional authorized to order genetic testing; acknowledges the patient has been supplied information regarding genetic testing and the patient has given consent for genetic testing to be performed and the signed consent form is on file. I confirm that this is medically necessary for the diagnosis or detection of a disease, illness, impairment, syndrome or disorder, and that these results will be used in the medical management and treatment decisions for this patient. Furthermore, additional results recipients information is true and correct to the best of my knowledge.

My signature here applies to the attached letter of medical necessity (if applicable). If you do not want your signature on this TRF to apply to the attached LMN, please provide an LMN and/or Clinical Notes with your order and check here. ☐

Does this patient give consent to the use of their sample for research? ☐ Yes ☐ No

Medical Professional Signature: _____ Date: _____

☐ INSURANCE BILLING (include copy of both sides of insurance card)

Patient Relation to Policy Holder? ☐ Self ☐ Spouse ☐ Child	Name and DOB of Policy Holder (if not self)	
Insurance Company	Policy #	HMO Authorization #

☐ PATIENT PAYMENT

☐ Check ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Card Number	Exp. Date	CVC #

Cardholder Name	Amount $

☐ INSTITUTIONAL BILLING

Facility Name	
Street Address	
City	
State	Zip Code
Contact Name	
Phone Number	E-mail

Billing ABN and Patient Protection Plan Information:
A completed Advance Beneficiary Notice (ABN) of coverage is required for Medicare patients who do not meet medical criteria for testing. Billing laboratory preverifies insurance coverage and will contact the patient after the patient's sample is received if the out-of-pocket amount for testing is estimated to exceed $100. Insurance pre-verification will not be performed for specific site analyses, unless specifically requested. All tests ordered with a bill type of insurance shall be processed and billed based on payor criteria.

Patient Acknowledgement: I acknowledge that the information provided by me is true to the best of my knowledge. For direct insurance/3rd party billing: I hereby authorize my insurance benefits to be paid directly to Dynix Diagnostix and authorize them to release medical information concerning my testing to my insurer. If applicable, I authorize Dynix Diagnostix to be my Designated Representative for purposes of appealing any denial of benefits. I acknowledge and agree that Dynix Diagnostix has the right to request additional medical records, such as consult notes, pedigrees, and clinical/family history notes directly from my provider(s) for the purpose of insurance verification and proper billing. I also fully understand that I am legally responsible for sending Dynix Diagnostix any money received from my health insurance company for performance of this genetic test. For patient payment by credit card: I hereby authorize Dynix Diagnostix to bill my credit card as indicated above.

Patient Signature: _____ Date: _____

Hereditary Cancer Test Requisition

Patient Name: _____ DOB: _____

INDICATIONS FOR TESTING (CHECK ALL THAT APPLY)

☐ Diagnostic (history of cancer or polyps) ☐ Family history of cancer ☐ Positive or normal control ☐ Other_____

ICD-10 code(s): _____

☐ Test results will affect immediate medical management, date results needed (if known): _____

PATIENT CLINICAL HISTORY ☐ no personal history of cancer

Cancer/Tumor	Age at Dx	Pathology and Other Info
Breast		Type: ER ☐(+) ☐(-) ☐unk PR ☐(+) ☐(-) ☐unk HER2/neu ☐(+) ☐(-) ☐unk
2nd primary breast		Type: ER ☐(+) ☐(-) ☐unk PR ☐(+) ☐(-) ☐unk HER2/neu ☐(+) ☐(-) ☐unk
Ovarian		☐ Fallopian tube ☐ Primary peritoneal
Prostate		Gleason score:
Hematologic		Type: ☐ Allogenic bone marrow or peripheral stem cell transplant
Other cancer		Type:

Other clinical history:

PATIENT TESTING HISTORY (PLEASE INCLUDE COPIES OF ANY PREVIOUS TEST RESULTS) ☐ No previous molecular and/or genetic testing

☐ Germline genetic testing Test(s) performed: _____ Result(s): _____

☐ Somatic test/tumor profile Test(s) performed: _____ Result(s): _____

FAMILY HISTORY* ☐ None (maternal) ☐ None (paternal) ☐ Maternal hx unknown ☐ Paternal hx unknown

*Completing this section is not mandatory for ordering if a pedigree and/or clinical note with family history is supplied, but is recommended and helps with results interpretation and claims filing.

Relation to patient	Maternal	Paternal	Cancer Type	Dx age	Relation to patient	Maternal	Paternal	Cancer Type	Dx age
	☐	☐				☐	☐		
	☐	☐				☐	☐		
	☐	☐				☐	☐		
	☐	☐				☐	☐		

TESTS REQUESTED

MULTI-GENE CANCER REPORT:

The following gene test(s) is clinically indicated:

☐ Breast, ovarian, uterine cancer full panel (32 gene cancer test)

HEREDITARY CANCER MULTIGENE TESTS SUPPLEMENTAL INFORMATION

Breast, ovarian, uterine, colorectal panel:

APC, ATM, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDKN2A, CHEK2, EPCAM, FH, FLCN, MLH1, MRE11A, MSH2, MSH6, MUTYH, NBN, PALB2, PMS2, PTEN, RAD50, RAD51C, RAD51D, RINT1, SDHB, SMAD4, STK11, TP53, VHL, XRCC2

Notes:

*Please make sure to indicate ethnicity on page 1.

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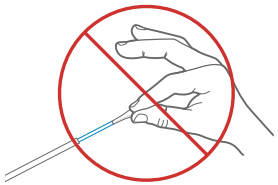
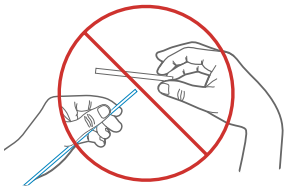
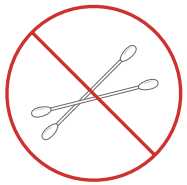
WARNING



DO NOT touch the tips of the swabs.



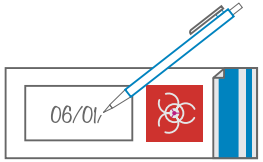
DO NOT remove the plastic straw from the plastic shaft of the swabs.



DO NOT use other specimen collection swabs or devices—the test only works with the validated swabs included in this collection kit.

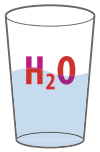
INSTRUCTIONS

Follow these steps to administer the test and get accurate results:



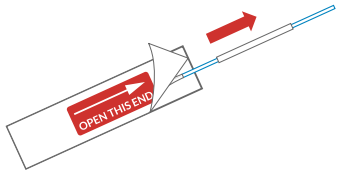
STEP 1:

Complete all of the information on the small clear DryPak envelope.



STEP 2:

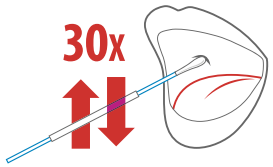
Rinse the patient's mouth with water.



STEP 3:

Remove one swab from its package.

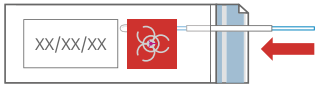
Tear open the package from the bottom and slide out one swab. Hold it by its plastic shaft—**Please DO NOT touch the tip of the cotton swab.**



STEP 4:

Ask the patient to open their mouth and place the tip of the cotton swab against the inside of their cheek. Rub the cotton swab back and forth against the inside cheek, about 30 times.

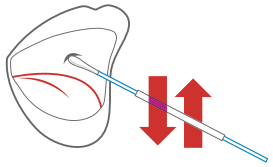
While you rub the cotton swab, turn the plastic shaft. This will ensure the entire tip is covered with cells from the cheek.



STEP 5:

Place the cotton swab into the small clear DryPak envelope.

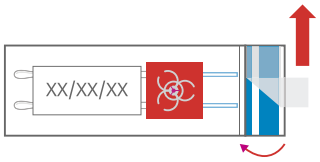
But don't seal the envelope yet!



STEP 6:

Remove the second swab from its package. Rub the tip against the inside of the patient's other cheek.

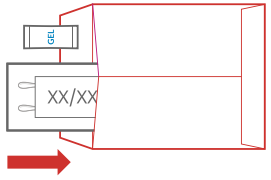
Repeat steps 4 and 5 with the other cheek. Remember, **DO NOT touch the tip** of the swab with your fingers.



STEP 7:

Place the second swab into the small clear DryPak envelope. Seal the DryPak envelope.

Check to make sure there are now 2 swabs in the small clear DryPak envelope. **DO NOT** place the gel pack or anything else in the DryPak. Seal the small clear envelope by taking off the protective strip. Push the flap down and press firmly.



STEP 8:

Put the desiccant package, clear DryPak envelope, and completed test requisition form into the large, clear Ziploc bag.

Before you seal it, make sure only the 2 swabs are sealed inside the small clear envelope. Don't forget the gel pack—it will protect the sample from moisture.

Complete the checklist on the outside of the Ziploc bag. Seal the Ziploc bag and follow instructions for sending the sample back to the testing laboratory.