

**LAB USE ONLY** DO NOT FILL OUT

Date received: Y _____ M _____ D _____

Specimen type: _____

Condition: _____

MRN: _____ Tech: _____

Form 1b: Uveal Melanoma Prognostic Genetic Test Requisition**Ordering Options** Uveal Melanoma Prognostic Genetic Test

▶ For BAP 1 Germline Analysis -Complete a BAP1 Test Requisition

Patient

Last name: _____

First name: _____

Date of birth: Y _____ M _____ D _____

Gender: Male Female

Ethnicity: _____

Pigmentation:

Skin color: _____ Hair color: _____

Eye color: _____

Specimen Information

Tumor collection method:

 FNAB Enucleation Surgical resection Other: _____

Tumor sample (required):

 Fresh tumor in cell lysis (Impact Genetics collection tube) Frozen tumor To follow (sending separately) DNA from tumor Other: _____

Date of collection: Y _____ M _____ D _____

Time of collection: HH:MM (24hr) _____

Normal/control sample (required):

 Buccal swab (UM Prognostic Test only) Blood (UM Prognostic Test and BAP1 Germline Analysis)

Date of collection: Y _____ M _____ D _____

Time of collection: HH:MM (24hr) _____

Histology

Tumor thickness* (by ultrasound, mm): _____

Largest basal tumor diameter** (LBD, mm): _____

Anatomic sub-classification:

 Choroid Iris Ciliary body involvement Other: _____Extraocular extension (spread) present: Yes No

Mitotic count: _____ per _____ HPF

Closed loops: Yes No

Predominant cellular classification:

 Pure spindle Predominantly spindle Epitheloid Predominantly epitheloid UnknownNecrosis: Yes No

AJCC TNM stage: _____

** These values are required for TNM survivorship prediction.

Patient History

Diagnosis date: Y _____ M _____ D _____

Type of primary management:

 None Proton beam radiotherapy Enucleation Plaque therapy Other: _____

Date: Y _____ M _____ D _____

Referring Specialist

Name: _____

Specialty: _____

Contact: _____

Telephone: _____ Fax: _____

Email: _____

Signature: _____

Institution: _____

Address: _____

City: _____ Prov/State: _____

Postal code: _____ Country: _____

Additional copies to: _____

Email: _____ Fax: _____

Billing

Impact Genetics tests ordered through LabCorp test menu.

USA only. a) Client Bill

Provide details: _____

 b) Patient Pay

Complete LabCorp Financial Responsibility Form.

 c) Third party insurance (USA only)

Complete Form 1c: U.S. Insurance Information and to expedite

testing, complete LabCorp Financial Responsibility Form.

Ordering Specialist: By submitting this form, I confirm that this test is being ordered for the purpose of prognosis as per the **Laboratory and Specimen Collection Centre Licensing Act** (Ontario, Canada).**1100 Bennett Road - Unit 4, Bowmanville, ON L1C 3K5****t: 647-478-4902 or 1-877-624-9769 f: 905-697-9786****e: info@impactgenetics.com** *Please ensure to use secure email*