impact genetics

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 ☐ Unknown

Necrosis: ☐ 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

☐ a) Institution

Provide details:

☐ b) Patient Pay

Complete ***Form 1d:*** *Credit Card Authorization for Non-Covered Services.*

☐ c) Third party insurance (USA only)

Complete ***Form 1c:*** *U.S. Insurance Information and to expedite testing, complete* ***Form 1d:*** *Credit Card Authorization for Non-Covered Services.*

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 0Y7
t: 647-478-4902 or 1-877-624-9769 f: 905-697-9786
e: info@impactgenetics.com *Please ensure to use secure email*