

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