impact genetics

LAB USE ONLY DO NOT FILL OUT

Date received: Y M D

Specimen type:

Condition:

MRN: Tech:

Form 1b: MLH1/MSH2/MSH6/PMS2/EPCAM Somatic Tumor MMR Sequencing and Deletion/Duplication Test Requisition

Patient

Last name:

First name:

Date of birth: Y M D

Gender: ☐ Male ☐ Female

Test Submission Requirements

1. ☐ MSI and/or IHC report
2. ☐ Normal Sample
   - ☐ Blood 5-10 ml
     Date Collected: Y M D
3. ☐ Tumor sample:
   - ☐ Formalin fixed paraffin embedded (FFPE) block (preferred)
     Date Collected: Y M D

or ☐ 19 serial unstained unbaked slides (5-10 microns thick) with 1 adjacent unstained unbaked slide (4 microns thick)
Date Collected: Y M D

or ☐ Impact Genetics to procure block as detailed below

Request for Impact Genetics to procure the FFPE sample on your behalf

Facility name:

Address:

City: Prov/State:

Postal code: Country:

Facility contact:

Telephone: Fax:

Email:

☐ *Patient is aware that the specimen is to be sent to Impact Genetics*

Previous Test Results

For MLH1 abnormal tumors:

Methylation analysis complete? ☐ Yes ☐ No
Result:

BRAF V600 analysis complete? ☐ Yes ☐ No
Result:

Germline analysis complete? ☐ Yes ☐ No
Result:

Please provide report. Include coding (c.) and protein (p.) nomenclature for germline variant and genome build used.

Patient History

Colon cancer: ☐ Yes ☐ No

Diagnosis date: Y M D

Other clinical information:

Family History

☐ Isolated Case ☐ Positive Family History
Please complete pedigree.

Pedigree

Referring Specialist

Name:

Specialty:

Contact:

Telephone: Fax:

Email:

Signature:

Institution:

Address:

City: Prov/State:

Postal/Zip 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.*

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e: info@impactgenetics.com *Please use secure email*