



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

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.

115 Midair Court, Brampton, ON L6 5M3

t: 647-478-4902 or 1-877-624-9769 f: 905-697-9786

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