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).

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