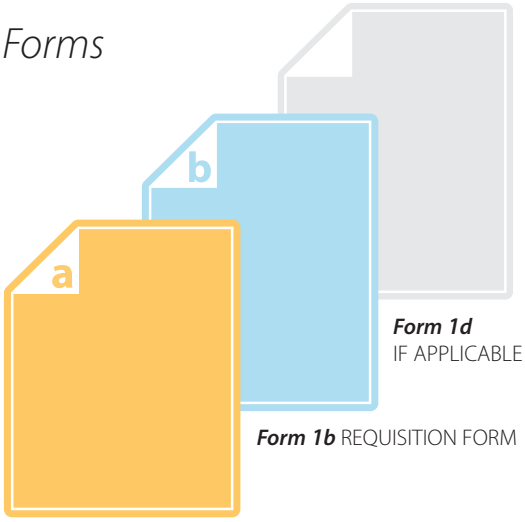
impact genetics

BAP1-TPDS (*BAP1* Tumor Predisposition Syndrome)

Genetic Test Submission Guide

1 Forms



Form 1d IF APPLICABLE

Form 1b REQUISITION FORM

Form 1a INFORMED CONSENT

2 Samples

3 Ship

Impact Genetics
115 Midair Court
Brampton, ON L6T 5M3
1-877-624-9769

Results

Rev 21Feb2020 (CAN)

impact genetics

Form 1a: *Informed Consent to Perform Genetic Testing*

The purpose of my DNA test/or my child's DNA test is to look for mutation(s) or genetic alterations known to be associated with the following genetic condition or disease: _____.

By signing below, I acknowledge that:

1. My participation or, as applicable, my child's participation in this DNA testing is voluntary. The decision to consent to, or to refuse the above testing is entirely mine.
2. This testing is done on small biological samples.
3. It is possible that the quantity or quality of sample submitted may be inadequate for testing or that a mutation cannot be identified.
4. When DNA testing shows a mutation or alteration, then the person is a carrier or is affected with that condition or disease, or, in the case of cancer genetic testing, the person is a carrier of a mutation or alteration that may be associated with an increased risk for certain cancer(s) compared to the general population. Consulting a doctor or genetic counsellor is recommended to learn the full meaning of the results and to learn if additional testing might be necessary.
5. When the DNA testing does not show a known mutation or alteration, the chance that the person is a carrier or is affected is reduced, or, in the case of cancer genetic testing, the person's risk for certain cancer(s) compared to the general population will depend on additional personal factors. There is still a chance to be a carrier or to be affected because the current testing cannot find all the possible changes within a gene.
6. Impact Genetics will disclose the test results ONLY to the specialist designated on the Requisition Form (***Form 1b***), or to his/her agent, unless otherwise authorized by the patient or required by law, except as described in point 11 below, no information will be printed or released that discloses the patient's identity, or other confidential information.
7. Impact Genetics is not a DNA banking facility and patient DNA samples may not be available for future testing.
8. An error in diagnosis may occur if the true biological relationships of the family members are not as stated in the pedigree submitted with the Requisition Form (***Form 1b***). It is possible that the test may disclose non-paternity (someone who is not the biological father), or some other previously unknown information about family relationships, such as adoption, and I consent that this finding be reported to the referring specialist designated below.
9. There is a chance that the test may reveal unexpected abnormalities that may be of medical value in the patient's care. Impact Genetics will inform the referring specialist designated below.
10. Until the results of this test are reported, the patient and members of the patient's family should still undergo examinations as prescribed by the referring specialist.
11. If necessary to obtain reimbursement of test fees, Impact Genetics, its agents and legal representatives may disclose information that identifies the patient or other confidential information (including test results).
12. I have read or have had read to me, the above information and I understand it. I have also read or had explained to me the specific disease or condition tested for, and the specific test(s) I am having, including the test descriptions, principles and limitations. I have had the opportunity to discuss the purposes and possible risks of this testing with my doctor or someone my doctor has designated.

Consent for Future Research:

After all analysis required to reach a genetic diagnosis is complete, Impact Genetics has my consent to use any surplus DNA or RNA in an **anonymous** fashion for research. No tests(s) will be performed and reported on my sample other than the one(s) authorized by my doctor.

☐ YES ☐ NO

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

impact genetics

LAB USE ONLY DO NOT FILL OUT

Date received: Y M D

Specimen type:

Condition:

MRN: Tech:

Form 1b: *BAP1-TPDS Genetic Test Requisition* *(BAP1 Tumor Predisposition Syndrome)*

Patient

Last name:

First name:

Date of birth: Y M D

Gender: ☐ Male ☐ Female

Ordering Options

☐ **Proband** - *BAP1* full sequencing and copy number

☐ **Known familial mutation** - *BAP1* targetted sequencing

Has the Patient had uveal melanoma prognostic testing done at Impact Genetics?

☐ Yes ☐ No

Sample

☐ **Blood** – 10ml EDTA Date Collected: Y M D

☐ **DNA from blood stored at Impact Genetics**
Please call to ensure sufficient volume is available.

Clinical History *– Check all that apply*

☐ Uveal melanoma

☐ Mesothelioma

☐ Melanocytic skin tumors

☐ Renal cell carcinoma

☐ Other (specify type):

Family History

☐ Isolated Case ☐ Positive Family History
Please complete pedigree.

Relationship to Patient:
Type of cancer:
Age at diagnosis:

Relationship to Patient:
Type of cancer:
Age at diagnosis:

Relationship to Patient:
Type of cancer:
Age at diagnosis:

Pedigree

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.*

How to arrange genetic counselling

Patient is required to login to genetic counseling services portal: **http://impactgenetics.com/genetic_counseling/,**

Or call, **855 GC CALLS (855-422-2557).**

Telegenetics appointment will be scheduled at which time genetic counseling will be provided by a board certified genetic counselor.

115 Midair Court, Brampton, ON L6T 5M3
t: 647-478-4902 or 1-877-624-9769 f: 905-697-9786
e: info@impactgenetics.com *Please ensure to use secure email*
Rev 19Feb2020 (CAN)

PLEASE DO NOT SEND FORM WITH SAMPLE;
Send this form to Impact Genetics
BY FAX TO 905-697-9786
For patient pay, testing will be held pending receipt of this completed form.

impact genetics

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

To be completed by and returned to Impact Genetics ***directly by the cardholder****.*

Billing Information

Laboratory Test:

☐ Retinoblastoma Genetic Test
☐ NeuroSURE℠: Epilepsy Gene Panel Test
☐ HHT Genetic Test
☐ Uveal Melanoma Prognostic Genetic Test
☐ *BAP1*-TPDS (*BAP1 Tumor Predisposition Syndrome*) Genetic Test
☐ *MLH1/MSH2/MSH6/PMS2/EPCAM* Somatic Tumor MMR Genetic Test

Patient name: _____ Date of birth: Y ____ M ____ D ____

☐ VISA ☐ MASTERCARD

Name on card: _____

Billing address: _____

City: _____

Province/State: _____ Postal/Zip code: _____

Country: _____

Card #: _____ Expiration date: _____

CVC # *(3-digit Card Verification Code at back of card)*: _____

Contact Information

Impact Genetics will contact the cardholder prior to placing the credit card charge, to confirm the date and amount of the charge. Please ***provide at least 2 contact methods*** *and check preferred:*

☐ Phone: _____

☐ Email: _____

☐ Fax: _____

Statement of Financial Responsibility U.S. PATIENTS ONLY

Box below must be checked for testing to proceed.

☐ I understand that my insurance plan is not expected to pay for these test(s) at 100% and I agree to be personally and fully responsible for payment.

Cardholder's signature: _____ Date: _____

impact genetics

Step 2: *BAP1-TPDS (BAP1 Tumor Predisposition Syndrome) Genetic Test Sample Requirements*

U.S. insurance patients: a completed ***Form 1c****: U.S. Insurance Information* must be provided.
All submitted samples must be labeled with at least two patient identifiers (ie. name and date of birth)

Sample Requirements

Blood sample:

• 10 mls in lavender-topped EDTA tubes at room temperature, to be received within 5 days after draw.

Sample Identification:

• Label each sample with **at least two** patient identifiers (e.g. named and date of birth).

Step 3: *Shipping Requirements*

Multiple separated samples may be shipped in one box. Place multiple biohazard bags containing labeled samples into one box. Multiple boxes can be shipped in one courier envelope.

Shipping Instructions

• Ship samples to Impact Genetics at address shown on this page using a courier envelope.

• Include Informed Consent and Requisition Forms (***1a*** and ***1b)*** with the samples. Patients in the U.S. must also include U.S. Insurance Information (***Form 1c***) if required and not provided previously.

• Complete appropriate Air Waybill. If you cannot use FedEx or Purolator, please contact us.

• Place Air Waybill in the document pouch.

• For samples from outside of Canada, complete and sign appropriate customs forms (provided and available on our website; phone us if help is required). Place the customs forms in the document pouch.

• Within Canada, use **Purolator Express** (next-day) or **FedEx Priority** service (next-day). Outside of Canada use **FedEx Priority** service (next-day) and **use a FedEx "Clinical Pak"**. If you cannot use Purolator or FedEx, please contact us.

• Provide us with the parcel tracking number soon after courier pick-up: **647-478-4902, info@impactgenetics.com**.

• For emailed PDF FedEx waybills and customs forms, please contact us directly.

Send to Impact Genetics

mail: Impact Genetics
115 Midair Court
Brampton, ON L6T 5M3

tel: 1-877-624-9769

fax: 905-697-9786