Hereditary Cancer Testing
Analysis of *BRCA1* and *BRCA2* genes

BRAC*Analysis*®

myriad® WHEN DECISIONS MATTER

Myriad Genetic Laboratories, Inc.
320 Wakara Way
Salt Lake City, Utah 84108
United States of America

AFFIX ONE BAR CODE LABEL HERE

TEST REQUEST FORM

- To avoid delays please complete entire form
- Please print all information in BLOCK LETTERS

SPECIMEN COLLECTION DATE (REQUIRED) DD-MMM-YYYY: 30 FEB 1900

SPECIMEN COLLECTED BY (REQUIRED):

PATIENT

DATE OF BIRTH (DD-MMM-YYYY): 30 FEB 1900

GENDER: ☐ Male ☐ Female

PATIENT ID:

LAST NAME:

FIRST NAME:

BILLING INFORMATION

PAYOR ID:_____

or

RESEARCH #:_____

or

VOUCHER #:_____

ORDERING PHYSICIAN

LAST NAME:

DEGREE: Prof.

FIRST NAME:

CLINICAL ID:

INSTITUTION:

STREET, NR:

CITY, POSTAL CODE:

COUNTRY:

DAY PHONE:

FAX:

E-MAIL: _____

INTERNAL USE ONLY: Results to Myriad GmbH, # 116309

SEND RESULTS TO (Optional – additional clinician can be listed to receive status updates and the patient's copy of the results)

LAST NAME:

FIRST NAME:

INSTITUTION:

STREET, NR:

CITY, POSTAL CODE:

COUNTRY:

E-MAIL: _____

ANCESTRY AND CLINICAL HISTORY (Check all that apply)

☐ WESTERN/NORTHERN EUROPE ☐ CENTRAL/EASTERN EUROPE ☐ SOUTHERN EUROPE ☐ AFRICA ☐ SOUTH ASIA

☐ ASHKENAZI JEWISH ☐ LATIN AMERICA/CARIBBEAN ☐ ASIA ☐ NEAR EAST/MIDDLE EAST ☐ OTHER: _____

PATIENT'S PERSONAL HISTORY OF CANCER (Check all that apply)

☐ No personal history of cancer

☐ Breast Cancer	Age at DX:_____	☐ Triple Negative (ER-, PR-, HER2-) ☐ Ductal Invasive ☐ Lobular Invasive ☐ DCIS ☐ Bilateral ☐ Premenopausal ☐ Metastatic
☐ Ovarian Cancer	Age at DX:_____	☐ Results also needed for determining PARP inhibitor therapy
☐ Other Cancer(s)	Age at DX:_____	Type: _____

Check if applicable to patient:

☐ Bone Marrow Transplant Recipient Type: ☐ Autologous ☐ Allogeneic (if allogeneic please contact helpmed@myriadgenetics.eu)

☐ Blood Transfusion Recipient Type: ☐ Whole blood ☐ Packed red blood cells Date (DD-MMM-YYYY) 30 FEB 1900

☐ Current diagnosis of a hematologic cancer

FAMILY HISTORY OF CANCER Please indicate relationship, maternal or paternal, site of cancer, age at diagnosis (for breast cancer, indicate if bilateral, premenopausal, or triple negative)

☐ No Known Family History

Relationship	Maternal	Paternal	Cancer Site(s)	Age at Diagnosis
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

TEST REQUESTED

☐ BRAC*Analysis* – *BRCA1* and *BRCA2* gene sequencing and large rearrangement analysis for susceptibility to Hereditary Breast and Ovarian Cancer Syndrome

☐ Multisite 3 BRAC*Analysis*– Three mutation *BRCA1* and *BRCA2* analysis for individuals of Ashkenazi Jewish ancestry (BRCA1 c.68_69del (p.Glu23Valfs*17) BRCA1 c.5266dupC (p.Gln1756Profs*74) BRCA2 c.5946del (p.Ser1982Argfs*22)

☐ Reflex to BRAC*Analysis* if the Multisite 3 is negative ☐ Family member has tested positive for one of three mutations above

☐ Single Site BRAC*Analysis* – Mutation-specific analysis for individuals with a known *BRCA1* or *BRCA2* mutation in the family

Relationship: My Patient is the:_____ (e.g., maternal aunt) of the known mutation carrier. **Required:** Include a copy of the known mutation carrier's report.

Specify Gene ☐ *BRCA1* ☐ *BRCA2* Specify Variant (mutation): _____

☐ Other test: _____

I hereby authorize testing and confirm that informed consent has been obtained from the patient for specimen to be sent to Myriad for analysis. I confirm that this test is medically necessary and results will be used in the medical management and treatment decisions for the patient.

_____
Ordering Physician/Healthcare Provider's Signature

30 FEB 1900
Date (DD-MMM-YYYY)

INTERNAL USE ONLY: Bill Institution BIE _____.

If previous genetic testing of the *BRCA1* or *BRCA2* genes has been performed on this patient or a family member, the ordering physician or health care provider should inform the laboratory within two (2) business days of sending the specimen.

For information or questions regarding Myriad's privacy policy and patient education, please visit our website: http://www.myriadgenetics.eu