A test that provides cancer risk for all

MyRisk™
Hereditary Cancer Test

Myriad genetics

Myriad Genetic Laboratories, Inc.
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www.myriad.com
Outside U.S.A
Email: CustomerSupport@myriadgenetics.eu

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)

Specimen collected by (required)

Patient

Date of birth (DD-MMM-YYYY):	
Sex assigned at birth: ☐ Female ☐ Male	Patient ID:
Legal name (Last):	
Legal name (First):	

Billing information

Payor ID: _____
or
research #: _____
or
voucher #: _____

Ordering physician

Last name:	Degree:
First name:	Clinical ID:
Institution:	
Street, nr:	
City, postal code:	Day phone:
Country:	Fax:
E-mail:	

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:

Test requested

☐ **Myriad myRisk™ Hereditary Cancer***

☐ **Myriad myRisk™ Hereditary Cancer* Update Test** (available to patients previously tested negative with BRAC*Analysis*®, COLARIS®, and/or COLARIS *AP*®)

Accession number from previous Myriad report _____

☐ **BRAC*Analysis*®** - HBOC criteria

☐ **Multisite 3 BRAC*Analysis*®** - For patients of Ashkenazi Jewish ancestry
☐ Reflex to BRAC*Analysis*® if the Multisite 3 is negative ☐ Reflex to Myriad myRisk™ Hereditary Cancer if Multisite 3 is negative

☐ **Colaris®** - Lynch criteria

☐ **Colaris *AP*®** (Familial Polyposis syndrome criteria)

☐ **Single Site Testing** (for family of known mutation carriers) **Specify Gene:** _____ and **Mutation:** _____
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.

☐ **Other Test:**

*The genes associated with MyRisk™ Hereditary Cancer Panel are subject to change. To view the full list of genes available on the MyRisk™ panel, please visit: www.myriad.com/gene-table

Risk analysis options (tick to exclude from report):
- ☐ Do not include RiskScore®
- ☐ Do not include RiskScore® or Tyrer-Cuzick

Ancestry (Select all that apply)

☐ Ashkenazi Jewish ☐ Black / African ☐ Middle Eastern ☐ Pacific Islander
☐ Asian ☐ Hispanic / Latino ☐ Native American ☐ White / Non-Hispanic

Turn the page for additional patient information, test selection and authorized signature.

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Patient personal history of cancer and other clinical information (Select all that apply)

☐ No personal history of cancer

Patient has been diagnosed with:		Age at diagnosis	Patient is currently being treated	Pathology / Other Info
☐ Breast cancer	☐ Left ☐ Right		☐	☐ Ductal invasive ☐ Lobular invasive ☐ DCIS ☐ Metastatic ☐ Bilateral ☐ Premenopausal ☐ Triple negative (ER-, PR-, HER2-)
☐ Endometrial / Uterine cancer			☐	☐ Tumor MSI-High or IHC Abnormal - Result _____ ☐ Tumor not available for MSI-High or IHC Abnormal testing
☐ Ovarian cancer			☐	☐ Non-epithelial
☐ Prostate cancer			☐	Gleason Score _____ ☐ Metastatic
☐ Colon / Rectal cancer			☐	Type: ☐ Mucinous ☐ Signet ring ☐ Medullary growth pattern ☐ Tumor infiltrating lymphocytes ☐ Crohn's-like lymphocytic reaction ☐ Patient's tumor is MSI-High or IHC abnormal - Result _____ ☐ Tumor not available for MSI-High or IHC abnormal testing
☐ Colon / Rectal adenomas			☐	☐ Known Familial Adenomatous Polyposis (FAP) Cumulative Adenomatous Polyp #: ☐ 1 ☐ 2-5 ☐ 6-9 ☐ 10-19 ☐ 20-99 ☐ 100+
☐ Hematologic cancer			☐	
☐ Other cancer(s) (e.g. cancers of the stomach, pancreas, bile duct, kidney, ureter, brain, skin and others)			☐	Type: _____

Check if applicable to patient:	
	___% on one of the Lynch Syndrome Risk Models (PREMM$_5$, MMRpro, or MMRpredict)
	☐ Bone Marrow transplant recipient Type: ☐ Autologous ☐ Allogeneic (if allogeneic please contact **helpmed@myriadgenetics.eu**)
	☐ Blood transfusion recipient within 28 days of sample collection Type: ☐ Whole blood ☐ Packed red blood cells
	☐ Blood transfusion recipient within 12 months of sample collection Date: (DD-MMM-YYYY) ☐☐ ☐☐☐ ☐☐☐☐

Family history of cancer

☐ No known family history of cancer

Relationship to patient	Maternal (mother's side)	Paternal (father's side)	Cancer site	Age at each diagnosis
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

The MyRisk Plus Management Tool and RiskScore™ may not be reported without an accurate and specific personal and family history included.

Breast cancer risk model information

Height (cm):_____ **Weight** (kg):_____

Age at time of first menstrual period: _____

Is patient currently: ☐ Pre-Menopausal ☐ Peri-Menopausal ☐ Post-menopausal **Age of post-menopausal onset** _____

Has this patient had a live birth? ☐ No ☐ Yes: **patient's age at first child birth:** _____

Has patient ever used hormone replacement therapy? ☐ No ☐ Yes

If yes, treatment type: ☐ Combined ☐ Estrogen only ☐ Progesterone only

If yes, is patient a: ☐ **Current user:** Started _____ years ago
Intended use for_____ more years
☐ **Past user:** Stopped _____ years ago

Information about patient's female relatives:

Number of daughters: ____

Number of sisters: _____

Number of maternal aunts (mother's sisters): _____

Number of paternal aunts (father's sisters): _____

Other information:

Mammographic density:

Has the patient had her breast density assessed? ☐ No ☐ Yes

If yes, complete one of the following for the most recent assessment:

☐ Volpara® volumetric density: _____ %

☐ VAS percentage density: _____ %

☐ BI-RADS® ATLAS density (Select one of the following):
☐ Almost entirely fatty ☐ Heterogeneously dense
☐ Scattered fibroglandular density ☐ Extremely dense ☐ Unknown

NOTE: Risk associated with mammographic density is not incorporated into RiskScore (v.1), nor Tyrer-Cuzick (v.7) calculations provided on the clinical report.

Please indicate if the patient has had a breast biopsy showing one or more of the following results: ☐ N/A (No biopsy or none of the listed results)

☐ Hyperplasia ☐ Atypical hyperplasia ☐ LCIS ☐ Biopsy with unknown or pending results

Authorized signature (Physician / healthcare provider)

I hereby authorize testing and confirm that informed consent has been obtained from the patient for blood or saliva 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. I hereby declare that the clinical information described on this Test Request Form is correct and belongs to the patient mentioned above. I hereby attest that the person listed in the ordering physician space above is authorized by law in the relevant jurisdiction to order the test requested herein.

Date (DD-MMM-YYYY) ☐☐ ☐☐☐ ☐☐☐☐

(Signature date is the specimen collection date if a different date is not provided above)

_____
Ordering physician / healthcare provider's signature

Internal use only: Bill Institution BIE _____.

If previous genetic testing of one of the requested 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.

Information

Cancel

Sex assigned at birth is a label given to an individual at birth, typically "male" or "female".

A legal name identifies a person for legal and administrative purposes. It is recorded on a birth certificate, marriage certificate, or other government issued document that records a name change.

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