12117 Bee Caves Rd. Building III, Suite 100 Austin, TX 78738
Tel: (844) 277-4721 Fax: (866) 283-3634 e-mail: support@ASPiRALAB.com
CLIA: 45D2073394 CAP: 9021192 NYS: 8885
Laboratory Director: Dr. Herbert Fritsche PhD

ASPIRA LABS®

Laboratory Test Requisition Form

TO AVOID DELAYS PLEASE COMPLETE FIELDS IN RED

Collection Date: _____ **Phlebotomist Initials:** _____ ☐ Physician Office ☐ Draw Site ☐ Other

Sample Type: ☐ Blood (1, 4mL EDTA Lavender top tube) ☐ Saliva ☐ Other:_____

ASPIRA GENETIX Hereditary Cancer (select panel)

◯ **BRCA1, BRCA2** (GTS-100)
BRCA1, BRCA2

◯ **Targeted Gynecologic Panel** (GTS-125)
ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, DICER, EPCAM, MLH1, MSH2, (mono/biallelic), MSH6, MRE11A, NBN, NFI, PALB2, PMS2, PTEN, RAD50, RAD51C, RAD51D, SMARCA4, STK11, TP53

◯ **Comprehensive Gynecologic Panel** (GTS-135)
ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1,CHEK2, DICER1, EPCAM, FANCC, MLH1, MRE11(A), MSH2, (mono/biallelic), MSH6, MUTYH, NBN, NF1, NTHL1 (mono/biallelic), PALB2, POLE, POLD1, PMS2, PTEN, RAD50, RAD51C, RAD51D, SDHB, SDHD, SMARCA4, STK11,TP53, WRN, XRCC2

For the latest test offerings please refer to https://aspirawh.com

PROVIDER INFORMATION

Physician name(s): _____ NPI#: _____
Name/Account #: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____
Email Address:_____
Fax copy to: _____

PATIENT INFORMATION

Last name: _____ First Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Email Address:_____
SSN: _____ DOB: __ __ / __ __ / __ __ __ __ Sex:_____
Phone number: _____
Ethnicities (Check all that apply)

☐ Caucasian ☐ Ashkenazi Jewish ☐ Sephardic Jewish
☐ East Asian ☐ South East Asian ☐ Hispanic
☐ Native American ☐ African American ☐ Other:_____

Indication for testing:_____

PHYSICIAN SIGNATURE

I attest that the patient has signed an informed consent or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. My signature certifies that I am a licensed medical professional or his/her representative who is authorized to order genetic tests on his/her behalf. The patient has been given the opportunity to ask questions about the attached consent and to seek outside genetic counseling.

STATEMENT OF MEDICAL NECESSITY
By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

Physician Signature: _____
Print Name: _____ Date: _____

PATIENT AUTHORIZATION

I have read the Informed Consent document and I give permission to ASPIRA LABS® to perform genetic testing as described. I affirm that my physician has offered genetic counseling and has reviewed and explained the benefits, risks, and limitations of the genetic test(s) to my satisfaction; that I have read and signed the informed consent form; and I would like to proceed with the genetic test(s). I also give permission for my specimen and clinical information to be used in de-identified studies as ASPiRA LABS® and for publication of study results, if appropriate ("Research"), or I have checked the box below to opt out of Research. My name or other personal identifying information will not be used in or linked to the results of any studies and publications. More information is available at https://aspirawh.com/about-us/legal/ I agree to assume responsibility for payment of charges that are not covered by my healthcare insurer.

☐ Opt out of Research

Patient's Signature: _____

Print Name: _____ Date: _____

BILLING INFORMATION

☐ Private Insurance ☐ Medicare ☐ Patient Self-Pay ☐ Medicaid ☐ Ordering Facility (Client Bill)

Insurance Information: Attach a copy of front and back of patient insurance card and complete.

Primary insurance carrier: _____ Member ID#: _____ Group ID#: _____

Secondary insurance carrier: _____ Member ID#: _____ Group ID#: _____

Name of insured: Last: _____ First: _____ DOB: _ _/ _ _/ _ _ _ _

Relationship to insured:
☐ Self ☐ Spouse ☐ Dependent ☐ Other

ICD-10 Codes: _____ /_____ /_____ /_____ /_____ /_____
Please see page 3 for a list of commonly used codes

Patient Name:_____ DOB:_____

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PLEASE PROVIDE PATIENT AND FAMILY HISTORY DETAILS BELOW

Please attach detailed medical records, insurance card front/back, and clinical information to the requisition form.

PERSONAL/FAMILY HISTORY (Check all that apply)

Attach pedigree and additional pages as needed

- ☐ No personal history of cancer
- ☐ Family History of Breast, Ovarian or Endometrial Cancer
- ☐ Previous cancer diagnosis? If yes, define:_____
- ☐ Somatic mutation profiling? If yes, define: (gene/variant identified)_____
- ☐ Previous germline testing? If yes, define: (gene/variant detected)_____

If yes is the variant: ☐ Familial/Inherited or ☐ Newly-identified/De Novo

Does the patient have a history of:	Yes	No	Which Cancer?	Age at Diagnosis?
Breast, ovarian or pancreatic cancer at any age?				
Colorectal or uterine cancer at 64 or younger?				

(Close relatives include: parent, sibling, child, uncle, aunt, great uncle, great aunt, nephew, niece, grandparent, grandchild, or half-sibling.)

Does the patient have a family history of:	Yes	No	Relative	Mothers Side?	Fathers Side?	Age at Diagnosis?
Breast Cancer at age 49 or younger?						
Two breast cancers (bilateral) in one relative at any age						
Three breast cancers in relatives on the same side of the family at any age						
Ovarian cancer at any age						
Pancreatic cancer at any age						
Male breast cancer at any age						
Metastatic prostate cancer at any age						
Colon cancer at 49 or younger						
Uterine cancer at 49 or younger						
Ashkenazi Jewish ancestry with breast cancer at any age						
Does the patient have a family history of other cancers?			If yes, please list:			
Has anyone in the patients family had genetic testing for hereditary cancer?			If yes, please list: Who, what genes and results (if known):			

Other Clinical History:

PREVIOUS OR CURRENT TREATMENT

☐ Allogeneic bone marrow or peripheral stem cell transplant* ☐ Chemotherapy* ☐ Radiation ☐ Surgery, specify:_____

*DNA analysis from blood samples of individuals who have undergone stem cell transplants, bone marrow transplants, or chemotherapy may not reflect the germline genotype. Similarly, DNA analysis from blood samples of individuals with hematologic malignancy may not distinguish between somatic and germline variants.

Patient Name:_____ DOB:_____

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Laboratory Test Requisition Form

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Please attach detailed medical records, insurance card front/back, and clinical information to the requisition form.

INSTRUCTIONS

1. Complete the patient and provider information section.
2. Have the patient read and sign the consent form. The complete patient informed consent form for genetic testing can be found on aspirawh.com. Signature from the provider on Page 1 of the TRF is required for all testing. Signature from the patient is only required for billing purposes.
3. Write in the test name on Page 1 or select the gene(s)/panel(s) below.
4. Indicate any relevant test options on Page 1.
5. Please visit aspirawh.com for specimen requirements.

REQUIRED FOR INSURANCE CHECKLIST

- ☐ Detailed medical record (pedigree if available)
- ☐ ICD-10 code(s)
- ☐ Physician and patient and signatures
- ☐ Copy of insurance card(s) - front / back
- ☐ Insurer specific forms (e.g. ABN)
- ☐ Insurance authorization, if available
- ☐ For Medicare, Patient history is required

RE-REQUISITION INSTRUCTIONS

Re-requisition for additional genetic testing is at no additional charge within 90 days of the original report release date. Any re-requisitioned test must be ordered from the same cancer category of tests. If you would like the results from the first test included in the next report, please also select the original test panels and genes.

1. Indicate which panels and genes you would like tested on this page.
2. Fill in the identifiers to the right based on the previous report.
3. If provider information and patient clinical information has not changed, only this third page is required for re-requisition.
4. It the provider information **has** changed, the first page is required.
5. If the patient's clinical information **has** changed, the second page is required.

Last name	First Name
Date of Birth	Report Accession ID
Provider Signature:	

COMMONLY USED ICD-10 CODES

- ☐ Z15.01 Genetic susceptibility to malignant neoplasm of breast
- ☐ Z15.02 Genetic susceptibility to malignant neoplasm of ovary
- ☐ Z15.03 Genetic susceptibility to malignant neoplasm of prostate
- ☐ Z15.04 Genetic susceptibility to malignant neoplasm of endometrium
- ☐ Z15.09 Genetic susceptibility to other malignant neoplasm
- ☐ Z15.81 Genetic susceptibility to multiple endocrine neoplasia [MEN]
- ☐ C25.0 Malignant neoplasm of head of pancreas
- ☐ C25.1 Malignant neoplasm of body of pancreas
- ☐ C25.2 Malignant neoplasm of tail of pancreas
- ☐ C25.3 Malignant neoplasm of pancreatic duct
- ☐ C25.4 Malignant neoplasm of endocrine pancreas
- ☐ C25.7 Malignant neoplasm of other parts of pancreas
- ☐ C25.8 Malignant neoplasm of overlapping sites of pancreas
- ☐ C25.9 Malignant neoplasm of pancreas, unspecified
- ☐ C48.1 Malignant neoplasm of specified parts of peritoneum
- ☐ C50.____ Malignant neoplasm of breast **[add anatomic site detail]**
- ☐ C56.1 Malignant neoplasm of right ovary
- ☐ C56.2 Malignant neoplasm of left ovary
- ☐ C56.9 Malignant neoplasm of unspecified ovary
- ☐ C57.00 Malignant neoplasm of unspecified fallopian tube
- ☐ C57.01 Malignant neoplasm of right fallopian tube
- ☐ C57.02 Malignant neoplasm of left fallopian tube
- ☐ C61 Malignant neoplasm of prostate
- ☐ D05.11 Intraductal carcinoma in situ of right breast
- ☐ D05.12 Intraductal carcinoma in situ of left breast
- ☐ Z80.0 Family history of malignant neoplasm of digestive organs [pancreas]
- ☐ Z80.3 Family history of malignant neoplasm of breast
- ☐ Z80.41 Family history of malignant neoplasm of ovary
- ☐ Z80.42 Family history of malignant neoplasm of prostate
- ☐ Z85.07 Personal history of malignant neoplasm of pancreas
- ☐ Z85.3 Personal history of malignant neoplasm of breast
- ☐ Z85.43 Personal history of malignant neoplasm of ovary
- ☐ Z85.46 Personal history of malignant neoplasm of prostate