BREAKTHROUGH GENOMICS

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Colon AiQ, Test Requisition Form
Early Colon Cancer Screening

PATIENT INFORMATION

Patient Last Name: _____ Patient First Name: _____ MI: _____

Date of Birth (MM/DD/YY): _____ Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Ethnic Background (check all that apply):
☐ African American ☐ Caucasian
☐ Asian/Pacific Islander
☐ Mediterranean ☐ Hispanic
☐ Native American ☐ Other

REFERRING PHYSICIAN INFORMATION

Name (Last, First, MI): _____ Provider NPI#: _____ Institution Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Genetic Counselor/Additional Recipient: _____ Phone/Fax/Email: _____

Preferred Method of reporting: ☐ Website Portal ☐ Fax ☐ Mail ☐ Phone

Location ID: _____

SAMPLE INFORMATION

Date Collected: _____

Date Received: _____

Collected By: _____

Sample Type: ☐ Blood ☐ Saliva ☐ DNA

CLINICAL INFORMATION

Clinical Indications: _____

ICD-10 codes: _____

Please check all of the following situations that apply:
☐ Patient has had transfusion within the past 30 days
☐ Patient has had bone marrow transplant

BILLING INFORMATION

☐ INSTITUTIONAL BILLING Institution Name and Contact: _____

☐ MEDICARE/MEDICAID Medicare/Medicaid No.: _____ State: _____

☐ INSURANCE BILLING *Please include a copy of insurance card(s) both front and back for billing purposes*

Policyholder Name: _____ DOB (MM/DD/YY): _____ Phone No.: _____

Insurance Co.: _____ Member ID: _____ Group No.: _____

☐ SELF PAYMENT (Invoice for payment will be issued upon receipt ofsample. Please completely fill out patient's address to avoid delay of testing)

Patient/ Guardian Acknowledgement for Financial Responsibility

I acknowledge that the information provided by me is true to the best of my knowledge. I hereby authorize my insurance benefits to be paid directly to Breakthrough Genomics and authorize them to release medical information concerning my testing to my insurer. I understand that I am financially responsible for any amounts not covered by my insurer for this test order. I also fully understand that I am legally responsible for sending Breakthrough Genomics any money received from my health insurance company for the performance of this genetic test. Failing to do so will result in my account being sent to collection.

Patient/ Guardian's Name: _____ Patient/Guardian's Signature: _____ Date: _____

INFORMED CONSENT FOR TESTING

I have supplied information to the patient regarding this DNA-based cancer screening testing and the patient has given consent for the testing to be performed. I further confirm that this test is medically important for the early detection or differential diagnosis of colon cancer, and the results will be used in the medical management and treatment decisions for the patient. I confirm that the person listed in the Ordering Physician space above is authorized by law to order the test requested.

Physician's Name: _____ Physician's Signature: _____ Date: _____

COLON CANCER RISK ASSESSMENT