LabPMM® an invivoscribe® company

Test Requisition Form

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Important Notice: LabPMM is not enrolled in the Medicare program and is unable to bill Medicare (or Medicare supplemental insurance) for any laboratory tests, including those that meet the Medicare criteria set forth in the "Laboratory Date of Service for Clinical Laboratory and Pathology Specimens" regulation (42 CFR Section 414.510(b)(5).

By submitting this Test Requisition Form, the ordering entity represents and warrants that the specimen is not for a Medicare patient and acknowledges and agrees that LabPMM will not refund any payment made to LabPMM in the event the entity submits a Medicare patient specimen in error.

Received Date:

Time: Tech:

Specimen Volume:

Tube/Container:

Accession #:

Place patient label here if desired

PATIENT INFORMATION *REQUIRED INFORMATION

Name*:

Date of Birth*:

Reported Ancestry:

Medical Record #: Gender: ☐ M ☐ F

GENE PANEL REQUESTED

☐ **MyAML®** Acute Myeloid Leukemia Sequence analysis of 194 genes

ABCC1, ACVR2B, ADRBK1, AKAP13, ANKRD24, ARID2, ARID4B, ASXL1, ASXL2, ASXL3, BCOR, BCORL1, BRINP3, BRPF1, BUB1, CACNA1E, CBL, CBX5, CBX7, CDC73, CEBPA, CEP164, CPNE3, CSF1R, CSTF2, TCTCF, CYLD, DCLK1, DDX1, DDX23, DHX32, DIS3, DNAH9, DNMT1, DNMT3A, DNMT3B, DYRK4, EED, EGFR, EP300, EPHA2, EPHA3, ETV3, EZH2, FANCC, FLT3, GATA1, GATA2, GFI1, GLI1, HDAC2, HDAC3, HNRNPK, HRAS, IDH1, IDH2, IKZF1, JAK1, JAK2, JAK3, JMJD1C, KDM2B, KDM3B, KDM6A, KDM6B, KIT, KMT2B, KMT2C, KRAS, MAPK1, METTL3, MST1R, MTA2, MTOR, MXRA5, MYB, MYC, MYLK2, MYO3A, NF1, NOTCH1, NOTCH2, NPM1, NRAS, NRK, OBSCN, PAPD5, PAX5, PDGFRA, PDGFRB, PDS5B, PDSS2, PHF6, PKD1L2, PLRG1, POLR2A, PRDM16, PRDM9, PRKCG, PRPF3, PRPF40B, PRPF8, PTEN, PTPN11, PTPN14, PTPRT, RAD21, RBBP4, RBMX, RPS6KA6, SAP130, SCML2, SETBP1, SETD2, SF1, SF3A1, SF3B1, SMC1A, SMC3, SMC5, SMG1, SNRNP200, SOS1, SPEN, SRRM2, SRSF2, SRSF6, STAG2, STK32A, STK33, STK36, SUDS3, SUMO2, SUPT5H, SUZ12, TCF4, TET1, TET2, THRB, TP53, TRA2B, TRIO, TTBK1, TYK2, TYW1, U2AF1, U2AF1L4, U2AF2, UBA3, WAC, WAPAL, WEE1, WNK3, WNK4, WT1, ZBTB33, ZBTB7B, ZRSR2 | ABL1, ADGRG7, AFF1, BCR, CBFB, CREBBP, DEK, EIF4E2, ELL, ETV6, GAS6, GAS7, KAT6A, KAT6B, KMT2A, ME-COM, MKL1, MLLT10, MLLT1, MLLT3, MLLT4, MYH11, NSD1, NUP214, NUP98, PICALM, PML , RARA, RBM15, RPN1, RUNX1, RUNX1T1, SEPT5, SET, TFG, TMEM255B

☐ **MyMRD®** NGS precision hotspot panel to detect and track myeloid malignancies of 23 genes

ASXL1, BRAF, CALR, CEBPA, CSF3R, DNMT3A, FLT3, IDH1, IDH2, JAK2, KIT, KMT2A, KRAS, MPL, MYH11, NRAS, NPM1, PTPN11, RUNX1, SF3B1, SRSF2, TP53, ZRSR2

PHYSICIAN/CLIENT INFORMATION *REQUIRED INFORMATION

Physician*:

Institution*:

Address*: Medicare #:

Address 2:

Phone*: Fax:

Email:

SPECIMEN TYPE

Peripheral Blood

☐ 2-4 mL in EDTA or Sodium Heparin

Bone Marrow

☐ 1-2 mL in EDTA or Sodium Heparin

Isolated DNA

☐ 1-2 µg from EDTA or Sodium Heparin

Transport specimens ambient (18-25°C/64-77°F) or with cold packs in provided packaging. If using cold packs for transport, make sure cold pack is not indirect contact with specimen. Do not freeze. Specimens should arrive in the laboratory within 48 hours of collection.

SAMPLE INFORMATION

WBC count:	%Blasts:	Diagnosis:
Tumor %:	Tissue Source:	ICD10 Code:
Date of Collection:	Time:	Reason for Submission:

Has the patient received an *Allogenic Stem Cell Transplantation*: ☐ Yes ☐ No

Please send all pathology and test results from all other molecular diagnostic assays.

RESEARCH

LabPMM® may use your leftover specimen and your health information, including genetic information, in an anonymized, or de-identified, form (unless otherwise allowed by applicable law) for research and education purposes. Such uses may result in the development of commercial products and services. You will not receive notice of any specific uses and you will not receive any compensation for these uses. All such uses will be in compliance with applicable law. You may refuse to allow LabPMM® to use your leftover specimen or information for research by marking the applicable box below. You may also withdraw your consent for research uses at a later date by submitting an "Opt-Out of Research Form" to the laboratory.

☐ Opt Out of Research Patient Signature: Date:

LabPMM® PATIENT INFORMED CONSENT

I, the patient, certify to having the assay performed, acknowledge that:

I understand that this test is voluntary and I have had the opportunity to ask questions and discuss with my healthcare provider the risks, benefits and alternatives of this test. I have been informed about the availability of genetic counseling and have been provided with information identifying an appropriate healthcare provider from whom I might obtain such counseling. I have read and understand the content of this document and may have a copy if desired. These test results may impact life, disability, and long-term care insurance. I understand that my sample will be tested for many different genes that may have conditions that impact me and my blood relatives. The American College of Medical Genetics and Genomics (ACMG) suggests that secondary findings be discussed with those who share these variants with me. I have considered the way to communicate this information to them.

Patient Signature: ______________________________