

Please Fax to 877-764-7628

6555 Sanger Rd Suite 260, Orlando FL 32827 CAP ID#: 8832145 | CLIA ID#: 10D2192649 CDPH ID#: CDS-90005103 | PA LAB ID#: 39259

Medical Director: Anthony Magliocco MD, FCAP

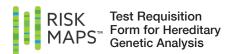
PRTEAN

Customer Service: 1 (754) 242 9682 or support@proteanbiodx.com

Patient Information						Authorized Provider Information								
Name (Last, First, MI)						Provider's NPI #						ax		
DOB (MM/DD/YYYY)	Female (XX)	Male (XY)	Phone (	primary)		Office / Practice / Institution Provider's Email								
Street Address			Street Address											
City	State	Postal Code		Country City State Postal C		Code	de Country							
Patient Email Address						Office Contact Name Contact Phone Contact Email					t Email			
MRN (Medical Record Numb		Specimen Collected by / Location:  (please check off correct response)    Patient / Home Address Listed to Left     Provider / Location Listed Above												
Insurance Billing Information														
Please send image of front and back of all insurance.														
ICD-10 Codes (List all ICD-10 codes below)  Cancer Type (list cancer type below)														
Specimen Information														
Specimen Type	Collect	ion Date (	DD/YYYY)	is meant to replace a previously submitted sample?										
□ Swab	☐ <b>Yes</b> , this is a replacement samp							mple [	ole    No, this is not a replacement					
Note: • Label tube with the patient's full name, DOB, & collection date. • A requisition form is required for each specimen.														
Risk MAPS <sup>™</sup> Panel Options (For a full list of genes covered, please refer to www.proteanbiodx.com/risk-panels)														
☐ Breast & Ovai		☐ Pancreatic Cancer Risk Panel: 23 Genes												
☐ Colorectal Ca		☐ Prostate Cancer Risk Panel: 19 Genes												
☐ Gastric Cance	☐ Combined Hereditary Cancer Risk Panel: 62 Genes													
☐ Total Comprehensive Cancer Risk Panel: 135 Genes														
Additional Panel Options:   Pharmacogenetics  Polygenetic Risk Scores														
Special Requests Collection Tube Barcode														
Certificate of Medical Necessity, Consent, Test Authorization, and Physician Signature														
By signing this form the medical professional acknowledges that the individual authorized to make decisions for the patient (Collectively as, the "Patient") has been supplied with all information regarding risks and has consented to have genetic testing performed as set forth in Protean's Informed consent. For orders outside of the US, the Patient has been informed their personal health information and sample will be processed in the US. The Patient has been informed that Protean may notify them of clinically relevant updates related to their genetic testing results (in consultation with ordering professional). The medical professional acknowledges that pretest and post test genetic counseling are required by the state of Florida for labs performing genetic analysis. The medical professional agrees to allow Protean to transfer the information from this test requisition form to a letter of medical necessity and/or other documents using the medical professionals name as the signature. I acknowledge that the Patient has agreed that if the Patient is insurer does not reimburse Protean in full for any reason then Protean may bill the Patient for the services rendered and the Patient will remit payment to Protean. For amounts that the Patient receives from their insurer, the Patient has agreed to remit payment to Protean for services rendered. I acknowledge that I offered pre-test counseling, or arranged for it to be performed, as required by Florida law and applicable insurance. I hereby attest that I am authorized under applicable law to order this test.														

Date

Ordering Physician Signature



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Patient Name (Last, First)



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Patient History of Cancer / Clinical Information										
Patient Diagnosis	Age at Diagnosis	Additional Information								
☐ Breast Cancer		□ TNBC (Triple Negative Bre     □ DCIS (Ductal Carcinoma in     □ ILC (Invasive Lobular Carci     □ IDC (Invasive Ductal Carci	n Situ)							
☐ Colon / Rectal Cancer										
☐ Colon / Rectal Polyps		Cumulative Polyp ☐ 1-9 ☐ 10-19 ☐ 20-99 ☐ 100+ Polyp Pathology:								
☐ Pancreatic Cancer										
☐ Prostate Cancer		☐ Metastatic Gleason Score	:							
☐ Endometrial / Uterine Cancer		☐ Tumor is IHC Abnormal or Tumor is MSI-high Results:								
□ Ovarian / Fallopian Tube / Peritoneal Cancer										
☐ Lung Cancer										
□ Other:										
Family History of Cancer										
Relation to Patient	Age at Diagnosis	Cancer Type								
□ Maternal □ Paternal										
□ Maternal □ Paternal										
□ Maternal □ Paternal										
□ Maternal □ Paternal										
Previous Genetic Testing										
Has the patient previously received genetic testing?  □ No □ Yes (indicate type):										
Shipping Information										
Please follow instructions in the prepaid envelope to ship kit to:	box, and us	e the enclosed	Email: support@proteanbiodx.com							
Protean BioDiagnostics 6555 Sanger Road Suite 260,	Orlando Fl	L 32827	Phone: 1 (754) 242 9682							