



Hereditary Cancer Requisition Form

Fax order to (650) 396-3046

GENETIC TEST	PATIENT INFORMATION			KIT INFORMATION
Hereditary Cancer Test (30 genes)	Patient's first name	Patient's last name	Sex <input type="radio"/> M <input type="radio"/> F	DOB (MM/DD/YYYY)
	Patient's address		City, state and zip	
	Patient's email address (required)	Patient's phone number	MRN (optional)	
				REQUIRED: BARCODE STICKER Attach barcode from the Color kit. Please ensure the barcode is for the kit your patient used. Sample collection date (MM/DD/YY)

PAYMENT INFORMATION			
Insurance company name	Member ID	Policy holder's first and last name	
Relationship to policy holder <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child <input type="radio"/> Other	Credit card #	Expiration date	Security code

Family Testing Program (eligible for Hereditary Cancer Test only)		
<input type="checkbox"/> This order is for Color's Family Testing Program	Patient's relation to the positive relative	Test results <i>Attach a copy of relative's positive test report</i>

ORDERING PROVIDER			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Institution or practice		Address	
City, state and zip	Phone number	Fax number	Email address

ADDITIONAL RECIPIENTS (will receive copy of report)			
Healthcare provider's name	Phone number	Fax number (for results delivery)	Email address

PATIENT'S PERSONAL HISTORY		
Cancer/Tumor	Personal history	Age at Dx
Breast	<input type="radio"/> Yes <input type="radio"/> No	
<input type="checkbox"/> Triple negative (ER-, PR-, HER2-)		
<input type="checkbox"/> Multiple primaries		
Ovarian	<input type="radio"/> Yes <input type="radio"/> No	
<input type="checkbox"/> Check if non-epithelial		
Prostate (Gleason score \geq 7)	<input type="radio"/> Yes <input type="radio"/> No	
Pancreatic	<input type="radio"/> Yes <input type="radio"/> No	
Endometrial/Uterine	<input type="radio"/> Yes <input type="radio"/> No	
Colon/Rectal	<input type="radio"/> Yes <input type="radio"/> No	
Stomach	<input type="radio"/> Yes <input type="radio"/> No	
Melanoma	<input type="radio"/> Yes <input type="radio"/> No	
Other cancer(s):		
ICD-10 codes:		

OTHER PERSONAL INFORMATION	
<input type="checkbox"/> Ashkenazi Jewish descent	<input type="checkbox"/> Previous genetic testing for hereditary cancer
<input type="checkbox"/> Bone marrow transplant recipient	<input type="checkbox"/> Current diagnosis of a hematologic cancer

FAMILY HISTORY OF CANCER			
Relationship	Maternal or Paternal	Cancer site(s)	Age at Dx
	<input type="radio"/> <input type="radio"/>		
	<input type="radio"/> <input type="radio"/>		
	<input type="radio"/> <input type="radio"/>		
	<input type="radio"/> <input type="radio"/>		
	<input type="radio"/> <input type="radio"/>		
	<input type="radio"/> <input type="radio"/>		
	<input type="radio"/> <input type="radio"/>		
	<input type="radio"/> <input type="radio"/>		
	<input type="radio"/> <input type="radio"/>		

- GENETIC COUNSELING** In the case of a positive result, patient **does not** require genetic counseling by a board-certified genetic counselor at Color.
- PATIENT RESULTS** Color will automatically release results to your patient after 20 days. If you would like your patient to view their results earlier, you can manually release the results.
- VUS DETAILS** *In the event a Variant of Uncertain Significance (VUS) is identified, you and your patient will receive the technical details in the report. Place your order online with the Color Provider Platform to change this order setting.*
- MEDICAL NECESSITY** Required for insurance I attest that this test is medically necessary for the diagnosis or detection of a disease or disorder, and that the results will be used in medical management and care decisions for the patient.
- INFORMED CONSENT** If unchecked, patient must consent online using their Color account I attest that the patient has read the Color Informed Consent or had it read to him or her, and that I have fully informed the patient about the purpose, capabilities and limitations of the indicated Color genetic test. The patient has voluntarily given full consent for the indicated Color genetic test, and a signed copy of this consent is available on file. Any Color Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

Ordering physician signature	Date
------------------------------	------

By submitting this Test Requisition Form, I attest that I am the ordering physician or am authorized under applicable laws and regulations to order genetic testing for the patient. If the patient's credit card information has been submitted, I also attest that the patient has authorized me to select the self-pay option and enter his or her payment information on his or her behalf. The patient has authorized Color and its designees to share the information on this form and related ordering information with his/her insurer for the purpose of processing, receiving payment, and appealing claims on behalf of the patient, and has agreed that any insurance payment sent directly to him/her will be remitted to Color within 30 days. The patient has also been informed that he/she shall be responsible for any co-pays, deductibles, and co-insurance, and any other amounts not paid by insurance. I agree to Color's transfer of the information in this form and the ordering physician's name to a Letter of Medical Necessity as authorization for insurance billing. I further attest that any information entered on this Test Requisition Form, or otherwise provided by me on behalf of the patient, is true and correct to the best of my knowledge, and that the patient has consented to receive communications about his/her genetic test from Color. This genetic test and related services are governed by Color's Terms of Service, and information provided on this Test Requisition Form is subject to Color's Privacy Policy, both of which are available at color.com or upon request.