



Test Requisition Form

Fax orders to (650) 396-3046

GENETIC TEST		HOW IS YOUR PATIENT RECEIVING THEIR COLOR KIT? (select only one)	
Hereditary Cancer Test (30 genes)		<input type="checkbox"/> Option 1: Shipped to patient's home	
		Your patient will receive an email to purchase their test directly through the link provided in the email.	
		<input type="checkbox"/> Option 2: In provider's office	
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)	Credit card number
		Expires (MM/YY)	Security code
Family Testing Program (eligible for either Hereditary Cancer or Hereditary Heart Health 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>
PATIENT INFORMATION			
Patient's first name		Patient's last name	
Date of birth (MM/DD/YYYY)		Sex <input type="radio"/> Male <input type="radio"/> Female	
Patient's address		City, state and zip	
Patient's email address (required)		Patient's phone number	MRN (optional)
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

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.*

INFORMED CONSENT ☐ 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.

If unchecked, patient must consent online using their Color account

Ordering physician signature

Date

By completing and 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 enter his or her payment information on his or her behalf. 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.

FOR INTERNAL USE ONLY

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