To avoid testing delays, this form must be completed in its entirety for all orders.

Hereditary Cancer Patient & Family Clinical History Form

Client Account Number: ______________________ **Client Name:** ______________________

Patient Name: ______________________ **Patient DOB:** ______________ **Patient Phone:** ______________

1 Ethnicity (Please select all that apply)

☐ African American/Black ☐ Native American ☐ Western/Northern European ☐ Middle/Near Eastern ☐ Other, specify: __________

☐ Hispanic ☐ Asian ☐ Eastern/Central European ☐ Jewish (Ashkenazi)

2 Patient History

Previous genetic testing ☐ Yes ☐ No **If yes, a copy of the patient's previous genetic test report must be faxed (1.855.422.5181) or emailed (Preauthorization@QuestDiagnostics.com)**

Does patient have a Lynch syndrome risk model score of ≥ 2.5% (e.g., PREMM5)? ☐ Yes ☐ No

Bone marrow transplant recipient ☐ Yes* ☐ No Current diagnosis of hematological malignancy ☐ Yes* ☐ No

If the patient has no history of cancer, please skip to the next section.

Cancer Type/Location	*(Optional: Please check boxes that apply, if known)*	Age at Diagnosis
☐ Breast *(If checked, select all that apply below)* ☐ Invasive ductal ☐ Invasive lobular ☐ DCIS	☐ Bilateral ☐ Premenopausal ☐ Triple Negative (ER-,PR-,HER2-)	
☐ Ovary	☐ Non-epithelial	
☐ Colon/Rectal	Tumor testing: ☐ MSI-H ☐ Abnormal IHC Features: ☐ Mucinous ☐ Signet ring ☐ Medullary growth pattern ☐ Crohn's-like lymphocytic reactions ☐ Tumor-infiltrating lymphocytes	
☐ Colon/Rectal Polyps	Amount: ☐ 0-10 ☐ 11-20 ☐ > 20 Type: ☐ Adenoma ☐ Other______	
☐ Endometrial/Uterine	Tumor testing: ☐ MSI-H ☐ Abnormal IHC	
☐ Other, specify:		

Has anyone in the family tested positive for a hereditary cancer syndrome (i.e., BRCA or Lynch) or other gene mutation? ☐ Yes ☐ No

If yes, a copy of the family member's genetic test report must be faxed (1.855.422.5181) or emailed (Preauthorization@QuestDiagnostics.com). Please label the family member's test result with the patient's name and how the family member is related (example, maternal aunt of Jane Smith).

If yes, will a blood sample from the family member that tested positive (positive control) be provided? ☐ Yes*† ☐ No

*If yes, please call 1.866.GENE.INFO ***before*** sending a specimen to discuss this order † ACMG guidelines, CAP and CLIA regulatory provisions recommend use of a positive control

3 Family History (Please check here if no known family history of cancer ☐)

Relationship to Patient	Maternal /Paternal	Cancer Location (Indicate cancer type and/or associated findings like colon polyps)	Age at Diagnosis	Living or Deceased?

4 Patient Acknowledgement

I authorize Quest Diagnostics (Quest) to release any information received, including, without limitation, medical information, which includes laboratory test results, to my health plan/insurance carrier and its authorized representatives as necessary for reimbursement. I further authorize my health plan/insurance carrier to directly pay Quest for the services rendered. I understand that I may be responsible for portions of the cost of this test not covered by my insurance.

Date: ______________________ Patient Name (Print): ______________________

Patient Signature: ______________________

Please fax or email the completed form to 1.855.422.5181 or Preauthorization@QuestDiagnostics.com.
For questions, please contact 1.855.509.4909 or email us at Preauthorization@QuestDiagnostics.com.

Hereditary Cancer Patient & Family Clinical History Form
Frequently Asked Questions

Why am I completing the Hereditary Cancer Patient and Family Clinical History Form?

Genetic testing may require special authorization from insurance companies. To help with this, please fill out the whole form. We understand that this form asks for very personal information. This information is needed for Quest Diagnostics to both work with the insurance company **and** interpret the results.

How do I know which box(es) to check in the ethnicity section?

Ethnic background is determined by which countries someone's relatives are from originally. Below is a chart that will help you determine which box(es) to check.

Ethnicity	Description
African American/Black	African, African American
Native American	Native American, American Indian
Western/Northern European	Austrian, British/English, Canadian, Danish, Dutch, Finnish, French, French-Canadian, Italian, Irish, Norwegian, Portuguese, Scandinavian, Scottish, German, Sephardic, Spanish, Swedish, Welsh
Middle/Near Eastern	Arabic, Armenian, Egyptian, Iranian, Iraqi, Pakistani, Persian, Saudi Arabian, Syrian
Hispanic	Bahamian, Brazilian, Caribbean, Colombian, Cuban, Dominican, Mexican, Puerto Rican, Haitian, Hispanic, Latin American
Asian	Chinese, Indian, Indonesian, Malaysian, Filipino, Samoan, Hawaiian, Vietnamese
Eastern/Central European	Czech, Polish, Romanian, Russian, Greek, Hungarian
Jewish (Ashkenazi)	A person of Jewish heritage who is (or whose family is) ethnically German, French, or Eastern European

What should I do with the form when I am done filling it out?

Give the form to the person drawing your blood. This will ensure that the form accompanies the blood sample to the lab.

What happens next?

Your test results will be sent to your doctor when they are ready.

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