TheraGuide® 5-FU

Genetic Analysis to Predict 5-FU Toxicity

Test Request Form

ENTIRE FORM MUST BE COMPLETED TO AVOID DELAYS

MYRIAD GENETIC LABORATORIES, INC.
A CLIA Certified Laboratory
320 Wakara Way • Salt Lake City, Utah 84108
(800) 469-7423 • (801) 584-1100
Fax (801) 584-3615 • info@myriad.com

SPECIMEN COLLECTION DATE (REQUIRED): 01/24/2010

NOTE: Affix Bar Code Label to Specimen Tube.

ORDERING PHYSICIAN

NAME (LAST, FIRST, DEGREE): Brown, Bob, MD
NPI#: 3456789012
MYRIAD ACCOUNT NO: (If new customer or account number is unknown, please complete the address info or call (800) 469-7423): 12345
ADDRESS:
CITY:
STATE:
ZIP:
OFFICE CONTACT: Shirley Tate
PHONE: 222-222-2222

SEND RESULTS TO (IF OTHER THAN ORDERING PHYSICIAN)

NAME (LAST, FIRST, DEGREE):
NPI#:
MYRIAD ACCOUNT NO: (If new customer or account number is unknown, please complete the address info or call (800) 469-7423)
ADDRESS:
CITY:
STATE:
ZIP:
OFFICE CONTACT:
PHONE:

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, INITIAL): Doe, Jane T
PATIENT ID#: 00000
☒ FEMALE ☐ MALE
BIRTH DATE (MM/DD/YYYY): 09/10/1945
STREET ADDRESS: 123 Generic Street
CITY: This City
STATE: ST
ZIP: 45678
DAYTIME PHONE NUMBER: 222-000-0000
ALTERNATE PHONE NUMBER:

ANCESTRY AND CLINICAL HISTORY

☐ WESTERN/NORTHERN EUROPE ☒ CENTRAL/EASTERN EUROPE ☐ AFRICA ☐ NEAR EAST/MIDDLE EAST
☐ ASHKENAZI ☐ LATIN AMERICAN/CARIBBEAN ☐ ASIA ☐ NATIVE AMERICAN ☐ OTHER _____

WHAT DRUGS HAS THIS PATIENT RECEIVED?

☒ NONE ☐ 5-FU + LEUCOVORIN ☐ CAPECITABINE ☐ FOLFOX ☐ FOLFIRI ☐ CAF ☐ CMF ☐ CF ☐ Other: _____

IF TREATED ALREADY WITH 5-FU OR CAPECITABINE, WHAT GRADE 3 OR 4 TOXICITY DID THIS PATIENT EXPERIENCE? ☐ NONE

GRADE 3 or 4: ☐ Diarrhea ☐ Stomatitis ☐ Hand & Foot ☐ Hematopoietic ☐ Other

WHAT KIND OF CANCER DOES THIS PATIENT HAVE?

☐ BREAST: Age at Dx: _____ ☐ COLORECTAL: Age at Dx: _____ ☐ HEAD & NECK: Age at Dx: _____ ☐ STOMACH: Age at Dx: _____
☐ CERVICAL: Age at Dx: _____ ☒ PANCREATIC: Age at Dx: 60 ☐ OTHER CANCER: _____ Age at Dx: _____

ICD-9 CODE(s)/Dx: 153.9 *(or applicable codes)*

HEALTHCARE PROVIDER'S SIGNATURE

I hereby authorize testing and confirm that informed consent has be… if required under state law.

(NOTE: Test requests without a signature will not be processed)

SIGN & DATE

Bob Brown, MD — Medical Professional Signature
01/24/2010 — Date

BILLING/PAYMENT INFORMATION (CHECK ONE OF THE FOLLOWING OPTIONS. TESTING WILL BE DELAYED WITHOUT COMPLETE PAYMENT INFORMATION.)

☒ **OPTION 1: PLEASE BILL MY INSURANCE** Option 1 requires patient signature and enlarged copy of both sides of insurance card(s). If two cards are submitted, indicate which is primary.

Name of Insured: Jane T. Doe DOB: 09/10/1945 Insurance ID#/ SSN#: ABC-123

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Authorization/Referral #: _____ *(Please attach copy of authorization/referral)*

I acknowledge I've selected insurance billing option, and hereby authorize Myriad Genetic Laboratories, Inc. ("MGL") to furnish my designated insurance carrier, health plan, or third-party administrator, (collectively "Plan"), the information on this form and other information provided by my healthcare provider if necessary for rei…rsement. I authorize my Plan to disclose to MGL information concerning my Plan, including coverage benefits and limitations, and payments made fo…rstand that I am responsible for any amount not paid by my Plan for reasons including, but not limited to, co-insurance, deductibles, non-covered …orized services. I permit a copy of this authorization to be used in place of the original.

REMINDER: INCLUDE A COPY OF BOTH SIDES OF YOUR INSURANCE CARD(S)

SIGN & DATE

Patient/Responsible Party Signature: Jane T. Doe Date: 01/24/2010

☐ **OPTION 2: PATIENT PAYMENT** (Please call Customer Service for questions regarding test prices.)

☐ Please bill my credit card (all major credit cards accepted) in the amount of $ _____ Card# _____ Exp. Date: _____

Cardholder Name (please print): _____ Cardholder Signature: _____

☐ Personal check, cashiers check, or money order enclosed, payable to Myriad Genetic Laboratories, Inc.

☐ **OPTION 3: OTHER BILLING**

☐ Bill our institutional account #_____ *(to establish an account, submit billing information with this form).* Established research project code #: _____

☐ Myriad has authorized testing for this patient. Authorization or Voucher number assigned: _____