Shodair Children's Hospital Genetics Laboratory
2755 Colonial Dr, Helena. MT, 59601
Phone (406) 444-7532 Toll Free (800) 447-6614
Fax (406) 444-1022
email: mtgene@shodair.org

INHERITED CANCER SCREEN REQUEST FORM

PATIENT INFORMATION

Counsyl will use this information to contact the patient via e-mail, SMS, and/or phone regarding screen processing status and online result access. By submitting this requisition, I confirm that I have obtained the patient's authorization to be contacted by Counsyl.

_____
Last Name

_____ _____
First Name **MI**

_____ / _____ / _____ Sex:
Date of Birth ☐ Female ☐ Male

_____ _____
Patient e-mail address *(required)* Patient Phone # *(required)*

_____
Patient Address

_____ _____ _____
City State ZIP

Ethnicity *select all that apply*

- ❑ Northern European *e.g. British, German*
- ❑ Southern European *e.g. Italian, Greek*
- ❑ French Canadian or Cajun
- ❑ Other/Mixed Caucasian
- ❑ East Asian *e.g. Chinese, Japanese*
- ❑ South Asian *e.g. Indian, Pakistani*
- ❑ Southeast Asian *e.g. Filipino, Vietnamese*
- ❑ African or African American
- ❑ Ashkenazi Jewish
- ❑ Hutterite
- ❑ Hispanic
- ❑ Middle Eastern
- ❑ Native American
- ❑ Pacific Islander
- ❑ Unknown

ORDERING HEALTH CARE PROFESSIONAL

Name: _____

NPI #: _____

Address: _____

City, State, Zip: _____

Telephone:(_____)_____ FAX:(_____)_____

REFERRING Facility:_____

AUTHORIZATION

By submitting this requisition , I confirm that I have obtained the patient's informed consent for the requested screening. I confirm that this screen is clinically valuable for the patient.

_____ _____
Signature of healthcare provider **Date**

CLINICAL INDICATION

Required.

❑ ICD-10 codes: _____

* Please attach second sheet of additional patient and/or family history if needed. Shodair and Counsyl will use patient and family history as supporting documentation for ICD-10 coding

INHERITED CANCER SCREEN

Specimen Requirements: Saliva or 4mL blood from collection kit **Sample Collection Date**: _____

Disease Panel *Required. Select one.*

- ❑ Comprehensive Panel
- ❑ Expanded Panel
- ❑ BRCA Panel
- ❑ Lynch Syndrome Panel
- ❑ Breast Panel
- ❑ Melanoma Panel
- ❑ Pancreatic Panel
- ❑ Gynecological Panel
- ❑ Gastrointestinal Panel
- ❑ Neuroendocrine Panel
- ❑ Other: _____
- ❑ Include variants of uncertain significance (VUS)

Personal History

1. Does the patient have a personal history of cancer? ❑ No ❑ Yes, personal history of (please provide details below)

Cancer Type *e.g breast, ovarian, colon, endometrial, pancreatic, prostate, etc. Please be as specific as possible. For example, for breast cancer, indicate type such as Ductal Carcinoma In Situ (DCIS).*	**Age** *At diagnosis*	**Pathology** *(optional)*	
		Type *e.g. MSI/IHC, ER/ PR/HER2*	**Result** *e.g. high/loss of MSH2, -/-/-.*

Family History

1. Is there a known hereditary cancer gene mutation in the family (e.g. BRCA1, BRCA2, MLH1, MSH2, etc.)?
   ❑ No/Unknown ❑ Yes, (required): Gene: _____ Mutation: _____
2. Does the patient have a family history of cancer? ❑ No ❑ Yes, family history of (please provide details below)

Cancer Type *e.g breast, ovarian, colon, endometrial, pancreatic, prostate, etc. Please be as specific as possible. For example, for breast cancer, indicate type such as Ductal Carcinoma In Situ (DCIS).*	**Relative** *e.g. mother, father, sister, brother, aunt, uncle, counsin, etc.*	**Lineage** *e.g. maternal or paternal*	**Age** *At diagnosis*

INTERNAL USE ONLY

Med Rec #	**Admit #**	**Date Received**	**Patient Barcode**

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Patient Name: _____ **DOB:** _____

INSTITUTIONAL BILLING

Institution: _____ Billing Contact: _____

Address: _____ Phone #: _____

City, State, Zip: _____ Fax #: _____

MEDICAID

Name of policy holder: _____ Passport #: _____

Policy holder DOB: _____ Phone #: _____

Address: _____ **MEDICAID** #: _____

City, State, Zip: _____ Medicaid State: _____

SELF PAY

Name of responsible party: _____

Relationship to patient: _____

Phone #: _____

INSURANCE BILLING

Name of policy holder: _____ Phone #: _____

Policy holder DOB: _____ Ins. Co. / Policy #: _____

Patient Relation to Policy Holder: _____ Ins. Co Contact / Phone: _____

SS # (Guarantor): _____

Address: _____

City, State, Zip: _____

Prior-Authorization Assistance *

❑ **YES** ❑ **NO** ❑ **N/A**

If Yes, please provide all clinical information

* PRIOR-AUTHORIZATION ASSISTANCE

Shodair's goal is to make the process of finding answers through genetic screening as easy as possible for patients and providers by providing assistance with the insurance benefit investigation / preauthorization process for inherited cancer screening. Shodair will perform a benefits investigation with the insurance plan listed above. For covered services, we will complete a prior-authorization when indicated. If the patient opts to not pursue testing, the ordering provider will be contacted. For non-covered services, we will contact the patient and offer a self-pay option. In the event we do not hear back from the patient in a 24 hour period, we will default to billing the insurance.

Preferred method(s) for contacting patient: _____

Pay your bill securely online at shodair.org/paying for services

INTERNAL USE ONLY

Med Rec #	Admit #	Date Received	Patient Barcode