

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



Hereditary Cancer Clinical History Form

Go to YourHistoryForm.com to complete this form online. If preferred, please complete the form below.

Client Account Number: _____ Client Name: _____

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Ethnicity (Please select all that apply)

- African American/Black Native American Western/Northern European Middle/Near Eastern Other: _____
 Hispanic Asian Eastern/Central European Jewish (Ashkenazi)

Genetic Testing History

Has the patient had previous genetic testing associated with hereditary cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes for any question, a copy of the patient's or family member's genetic test report must be faxed (1.855.422.5181) or emailed to Preauthorization@QuestDiagnostics.com . Please note the family member's relation to the patient on this report.
If yes, what sample type was tested? <input type="checkbox"/> Blood/Saliva <input type="checkbox"/> Tumor	
Has anyone in the patient's family tested positive for a genetic variant associated with hereditary cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, will a sample from the family member that tested positive be provided? ^a <input type="checkbox"/> Yes <input type="checkbox"/> No	

^a ACMG guidelines, CAP, and CLIA regulatory provisions recommend use of a positive control.

Patient History (Please check here if no relevant family history)

Bone marrow transplant recipient? Yes^b No Current diagnosis of hematological malignancy? Yes^b No

Lynch syndrome risk model score of $\geq 2.5\%$ (eg PREMM5)? Yes No

Breast cancer risk model score of $>5\%$ (eg Tyrer-Cuzick, BRCAPro, or PennII)? 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)	Age at Diagnosis
<input type="checkbox"/> Breast	<input type="checkbox"/> Bilateral <input type="checkbox"/> Premenopausal <input type="checkbox"/> Triple Negative (ER-,PR-,HER2-) <input type="checkbox"/> Invasive ductal <input type="checkbox"/> Invasive lobular <input type="checkbox"/> DCIS	
<input type="checkbox"/> Colon/Rectal	Tumor testing: <input type="checkbox"/> MSI-H <input type="checkbox"/> Abnormal IHC Features: <input type="checkbox"/> MSI High Histology	
<input type="checkbox"/> Colon/Rectal Polyps	Number: <input type="checkbox"/> 0-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> > 20 Type: <input type="checkbox"/> Adenoma <input type="checkbox"/> Other _____	
<input type="checkbox"/> Endometrial/Uterine	Tumor testing: <input type="checkbox"/> MSI-H <input type="checkbox"/> Abnormal IHC	
<input type="checkbox"/> Ovarian (peritoneal/fallopian tube)		
<input type="checkbox"/> Pancreatic	<input type="checkbox"/> Exocrine <input type="checkbox"/> Neuroendocrine	
<input type="checkbox"/> Prostate	<input type="checkbox"/> Gleason Score ≥ 7 <input type="checkbox"/> Metastatic <input type="checkbox"/> Intraductal	
<input type="checkbox"/> Other	Type of Cancer:	

^b If Yes, please call 1.866.GENE.INFO prior to sending a specimen to discuss this order.

Family History (Please check here if no relevant family history)

Relationship to Patient	Maternal	Paternal	Cancer Location <small>(Indicate cancer type and/or associated findings like colon polyps)</small>	Age at Diagnosis	Living or Deceased? <small>(Date of death)</small>
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			

For questions, please contact **1.855.509.4909** or email us at Preauthorization@QuestDiagnostics.com.

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Breast Cancer Risk Model Information (Only complete for female patients NEVER diagnosed with breast cancer)	
Patient Information:	Information About Patient's Female Relatives:
Height: ft: _____ in: _____ Weight (lbs): _____	Number of daughters: _____ Number of sisters: _____ Number of maternal aunts (mother's sisters): _____ Number of paternal aunts (father's sisters): _____
Patient's age at time of first menstrual period: _____	
Is patient currently: <input type="checkbox"/> Premenopausal <input type="checkbox"/> Perimenopausal <input type="checkbox"/> Postmenopausal: Age of postmenopausal onset: _____	
Has this patient had a live birth? <input type="checkbox"/> No <input type="checkbox"/> Yes — patient's age at first child's birth: _____	
Has patient ever used Hormone Replacement Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Treatment Type: <input type="checkbox"/> Combined <input type="checkbox"/> Estrogen only <input type="checkbox"/> Progesterone only	
If Yes, is Patient a: <input type="checkbox"/> Current User: started _____ years ago Intended use for _____ more years <input type="checkbox"/> Past User: stopped _____ years ago	
Please indicate if the patient has had a breast biopsy showing one or more of the following results: <input type="checkbox"/> N/A (No biopsy or none of the listed results) <input type="checkbox"/> Biopsy with unknown or pending results <input type="checkbox"/> Hyperplasia <input type="checkbox"/> Atypical Hyperplasia <input type="checkbox"/> LCIS	

Patient Acknowledgement	
<p>I authorize Quest Diagnostics (Quest) to release 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 financially responsible for portions of this test not covered by my insurance, and that Quest will contact me prior to test start ONLY if my responsibility for coinsurance, deductible, and/or non-covered service is estimated to be greater than \$100. Tests without a signature will NOT be processed.</p>	
Patient/Representative Name (Print): _____	Date: _____
Patient/Representative 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.