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

Quest Advanced Oncology

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? ☐ Yes ☐ 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? ☐ Blood/Saliva ☐ Tumor	
Has anyone in the patient's family tested positive for a genetic variant associated with hereditary cancer? ☐ Yes ☐ No	
If Yes, will a sample from the family member that tested positive be provided?[a] ☐ Yes ☐ 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 ≥ 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
☐ Breast	☐ Bilateral ☐ Premenopausal ☐ Triple Negative (ER-,PR-,HER2-) ☐ Invasive ductal ☐ Invasive lobular ☐ DCIS	
☐ Colon/Rectal	Tumor testing: ☐ MSI-H ☐ Abnormal IHC Features: ☐ MSI High Histology	
☐ Colon/Rectal Polyps	Number: ☐ 0-10 ☐ 11-20 ☐ > 20 Type: ☐ Adenoma ☐ Other _____	
☐ Endometrial/Uterine	Tumor testing: ☐ MSI-H ☐ Abnormal IHC	
☐ Ovarian (peritoneal/fallopian tube)		
☐ Pancreatic	☐ Exocrine ☐ Neuroendocrine	
☐ Prostate	☐ Gleason Score ≥ 7 ☐ Metastatic ☐ Intraductal	
☐ 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 (Indicate cancer type and/or associated findings like colon polyps)	Age at Diagnosis	Living or Deceased? (Date of death)
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			

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

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Hereditary Cancer Clinical History Form

Breast Cancer Risk Model Information (Only complete for female patients NEVER diagnosed with breast cancer)

Patient Information:

Height: ft: _____ in: _____ | Weight (lbs): _____

Patient's age at time of first menstrual period: _____

Is patient currently: ☐ Premenopausal ☐ Perimenopausal
☐ Postmenopausal: Age of postmenopausal onset: _____

Has this patient had a live birth? ☐ No ☐ Yes — patient's age at first child's birth: _____

Has patient ever used Hormone Replacement Therapy? ☐ Yes ☐ No

If Yes, Treatment Type: ☐ Combined ☐ Estrogen only ☐ Progesterone only

If Yes, is Patient a: ☐ **Current User:** started _____ years ago
Intended use for _____ more years
☐ **Past User:** stopped _____ years ago

Information About Patient's Female Relatives:

Number of daughters: _____

Number of sisters: _____

Number of maternal aunts (mother's sisters): _____

Number of paternal aunts (father's sisters): _____

Please indicate if the patient has had a breast biopsy showing one or more of the following results:

☐ N/A (No biopsy or none of the listed results) ☐ Biopsy with unknown or pending results
☐ Hyperplasia ☐ Atypical Hyperplasia ☐ LCIS

Patient Acknowledgement

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.**

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**.