



Send samples to:
 1 Commercial Street, Branford, CT 06405
 Tel: **833-486-6260** / Fax: 516-953-8154
 Tax ID# 13-6171197 / CLIA# 07D2101517
 CT Lic#: CL-0830 / CAP #9283362

Please be sure to fill out all highlighted fields. Failure to fill them in may result in delayed testing and delivery of results.

PATIENT INFORMATION		REFERRING PROVIDER INFORMATION	
<i>Sema4 will use this information to contact the patient via automatic email SMS, and/or phone regarding payment, testing status, and online results access. By submitting this requisition, I confirm that I have obtained the patient's authorization to be contacted by Sema4 by these means (email address must be specific to patient listed on form).</i>		Name REQUIRED Genetic Counselor / Additional Clinician	
PATIENT EMAIL ADDRESS RECOMMENDED		NPI# REQUIRED	
PATIENT MOBILE/PRIMARY NUMBER REQUIRED		Clinic / Institution REQUIRED	
LAST NAME REQUIRED	FIRST NAME REQUIRED MI	Address REQUIRED	
DATE OF BIRTH REQUIRED MM / DD / YYYY		Telephone	
BIOLOGICAL GENDER REQUIRED <input type="checkbox"/> M <input type="checkbox"/> F		Fax	
PATIENT/CLIENT MRN		Sending Physician Practice: <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Referral Lab <input type="checkbox"/> Hospital - Inpatient <input type="checkbox"/> Hospital - Outpatient	
ADDRESS REQUIRED		MEDICAL PROVIDER SIGNATURE OF CONSENT REQUIRED BELOW: I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested. I have answered this person's questions. I have obtained informed consent from the patient or their legal guardian for this testing.	
CITY / STATE / ZIP REQUIRED		SIGNATURE REQUIRED	
ETHNICITY (Check all that apply) <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Jewish (Ashkenazi) <input type="checkbox"/> Portuguese <input type="checkbox"/> Other:		DATE MM / DD / YYYY	

PREVIOUS TESTING INFORMATION

Testing Information (Required) Available within 120 days of initial sample receipt at Sema4

Please complete the following information based on the previously reported hereditary cancer test:

Sema4 Lab#: _____ Panel test name: _____

RE-REQUISITION LABORATORY TEST(S) ORDERED

Test Selection (Required) **SEMA4 SIGNAL HEREDITARY CANCER TESTING MENU**

<input type="checkbox"/> Ashkenazi Jewish BRCA Panel (3 variants) <input type="checkbox"/> Brain/Neurological Panel (32 genes) <input type="checkbox"/> BRCA1 and BRCA2 Panel (2 genes) <input type="checkbox"/> Breast and Gynecological Panel (27 genes) <input type="checkbox"/> Breast Guidelines Panel (11 genes) (includes guideline recommendations) <input type="checkbox"/> Run STAT for surgical decision making <input type="checkbox"/> Colorectal Panel (20 genes) <input type="checkbox"/> Comprehensive Panel (72 genes) <input type="checkbox"/> Endocrine Tumor Panel (21 genes) <input type="checkbox"/> High Prevalence Panel (36 genes)	<input type="checkbox"/> Lynch Syndrome Panel (5 genes) <input type="checkbox"/> Melanoma Panel (9 genes) <input type="checkbox"/> Pancreatic Panel (21 genes) <input type="checkbox"/> Pancreatic Plus Panel (27 genes) <input type="checkbox"/> Pediatric Panel (49 genes) <input type="checkbox"/> Prostate Panel (15 genes) <input type="checkbox"/> Renal/Urinary Panel (25 genes) <input type="checkbox"/> Universal Panel (112 genes) <input type="checkbox"/> Custom gene(s) testing : _____ <i>please select gene(s) to include below</i>
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HEREDITARY CANCER GENE LIST

SELECT GENES TO ADD

<input type="checkbox"/> AIP	<input type="checkbox"/> CDK4	<input type="checkbox"/> EPCAM	<input type="checkbox"/> FH	<input type="checkbox"/> MSH3	<input type="checkbox"/> POLH	<input type="checkbox"/> SDHAF2	<input type="checkbox"/> TP53
<input type="checkbox"/> ALK	<input type="checkbox"/> CDKN1B	<input type="checkbox"/> ERCC2	<input type="checkbox"/> FLCN	<input type="checkbox"/> MSH6	<input type="checkbox"/> POT1	<input type="checkbox"/> SDHB	<input type="checkbox"/> TSC1
<input type="checkbox"/> APC	<input type="checkbox"/> CDKN1C	<input type="checkbox"/> ERCC3	<input type="checkbox"/> GATA2	<input type="checkbox"/> MUTYH	<input type="checkbox"/> PRKAR1A	<input type="checkbox"/> SDHC	<input type="checkbox"/> TSC2
<input type="checkbox"/> ATM	<input type="checkbox"/> CDKN2A	<input type="checkbox"/> ERCC4	<input type="checkbox"/> GPC3	<input type="checkbox"/> NBN	<input type="checkbox"/> PRSS1	<input type="checkbox"/> SDHD	<input type="checkbox"/> VHL
<input type="checkbox"/> AXIN2	<input type="checkbox"/> CEBPA	<input type="checkbox"/> ERCC5	<input type="checkbox"/> GREM1	<input type="checkbox"/> NF1	<input type="checkbox"/> PTCH1	<input type="checkbox"/> SLX4	<input type="checkbox"/> WT1
<input type="checkbox"/> BAP1	<input type="checkbox"/> CFTR	<input type="checkbox"/> FANCA	<input type="checkbox"/> HOXB13	<input type="checkbox"/> NF2	<input type="checkbox"/> PTEN	<input type="checkbox"/> SMAD4	<input type="checkbox"/> XPA
<input type="checkbox"/> BARD1	<input type="checkbox"/> CHEK2	<input type="checkbox"/> FANCB	<input type="checkbox"/> HRAS	<input type="checkbox"/> NHP2	<input type="checkbox"/> RAD50	<input type="checkbox"/> SMARCA4	<input type="checkbox"/> XPC
<input type="checkbox"/> BLM	<input type="checkbox"/> CPA1	<input type="checkbox"/> FANCC	<input type="checkbox"/> KIT	<input type="checkbox"/> NOP10	<input type="checkbox"/> RAD51C	<input type="checkbox"/> SMARCB1	<input type="checkbox"/> XRCC2
<input type="checkbox"/> BMPR1A	<input type="checkbox"/> CTC1	<input type="checkbox"/> FANCD2	<input type="checkbox"/> MAX	<input type="checkbox"/> NTHL1	<input type="checkbox"/> RAD51D	<input type="checkbox"/> SPINK1	
<input type="checkbox"/> BRCA1	<input type="checkbox"/> CTRC	<input type="checkbox"/> FANCE	<input type="checkbox"/> MEN1	<input type="checkbox"/> PALB2	<input type="checkbox"/> RB1	<input type="checkbox"/> STK11	
<input type="checkbox"/> BRCA2	<input type="checkbox"/> DDB2	<input type="checkbox"/> FANCF	<input type="checkbox"/> MET	<input type="checkbox"/> PDGFRA	<input type="checkbox"/> RECQL4	<input type="checkbox"/> SUFU	
<input type="checkbox"/> BRIP1	<input type="checkbox"/> DICER1	<input type="checkbox"/> FANCG	<input type="checkbox"/> MITF	<input type="checkbox"/> PHOX2B	<input type="checkbox"/> RET	<input type="checkbox"/> TERC	
<input type="checkbox"/> CASR	<input type="checkbox"/> DIS3L2	<input type="checkbox"/> FANCI	<input type="checkbox"/> MLH1	<input type="checkbox"/> PMS2	<input type="checkbox"/> RTEL1	<input type="checkbox"/> TERT	
<input type="checkbox"/> CDC73	<input type="checkbox"/> DKC1	<input type="checkbox"/> FANCL	<input type="checkbox"/> MRE11	<input type="checkbox"/> POLD1	<input type="checkbox"/> RUNX1	<input type="checkbox"/> TINF2	
<input type="checkbox"/> CDH1	<input type="checkbox"/> EGFR	<input type="checkbox"/> FANCM	<input type="checkbox"/> MSH2	<input type="checkbox"/> POLE	<input type="checkbox"/> SDHA	<input type="checkbox"/> TMEM127	

Informed Consent for Hereditary Cancer Genetic Testing

I, _____, hereby request genetic testing for

Myself

My child _____

I have received verbal and written information (please see sema4.com/testcatalog for test-specific information sheet) from my physician or from a genetic counselor that described, in words that I understood, the nature of the genetic testing that I/my child am about to undergo.

The nature of the genetic test, _____, has been explained to me and the accuracy of the test and its risks and limitations have been detailed. I understand that specimen(s), such as peripheral blood, saliva, cheek swab, or skin biopsy will be taken from me/my child. I understand that this test will include exome sequencing, which generates data on the portion of my/my child's DNA selected by Sema4 that is comprised of key genes that carry instructions for the body's development and function. However, only the information set forth above will be reported back to me, and no test will be performed on my/child's sample other than the one(s) authorized by me and my healthcare provider.

I understand that this hereditary cancer test will analyze my/my child's sample to determine if I have /my child has a genetic disease, are carriers of a genetic disease or are more susceptible to develop a genetic disease or medical condition. The results may also suggest that I am/my child is affected with a condition that is different than, and/or that is in addition to, those considered for the purpose of consenting for this test. I further understand that my or my child's genetic test results may have implications for the rest of the family as genetic changes can be inherited.

I understand that there are several types of genetic test results, including:

- **Positive**, meaning that a pathogenic/likely pathogenic variant that is associated with an increased risk to develop cancer has been identified. The specific type(s) of these risks can vary depending on the gene in which the variant is found. A positive result may have medical management implications. For certain genes/variants, the cancer risks are not well established at this time, and more data and specific medical management recommendations related to these genes may evolve over time.
- **Negative**, meaning that no pathogenic/likely pathogenic variant(s) were identified. A negative result reduces, but does not eliminate, the possibility that I carry / my child carries pathogenic/likely pathogenic variant(s) in the genes analyzed or in other genes that are not included in the test. I/my child still have the general population's risk for developing cancer and may also be at a higher risk to develop cancer based on personal/family history.
- **Inconclusive**, meaning that an alteration was identified in the genes tested where there is insufficient information at this time to determine if such alteration is associated with increased cancer risks.

I will discuss any appropriate medical intervention with my healthcare provider before taking any action based on my/my child's results, and I will provide my/my child's genetic test result and personal/family history to my healthcare providers so that they can make an appropriate recommendation.

I understand that although the likelihood of an incorrect diagnosis or a misinterpretation of the result is extremely small, infrequent errors may occur. I understand that this testing may yield results that are of unknown clinical significance and that parental and/or other relative's specimens may also be tested or requested to determine whether a specific finding is inherited. In addition, incidental findings that are not related to the primary diagnosis may be identified in me/my child. An error in the diagnosis may occur if the true biological relationships of the family members involved in this study are not as I have stated.

There are some federal and state laws that address genetic discrimination. The US Genetic Information Nondiscrimination Act (GINA) may prohibit discrimination by employers and health insurances. This law, however, does not protect people in the military nor possible discrimination by other types of insurance such as life, disability or longterm care.

Sample storage for future clinical purposes

Sema4 may securely store a portion of my/my child's sample indefinitely for the sole purpose of performing future clinical testing that I authorize and consent to. My sample will not be used for any other purpose without my consent, and no test will be performed on my sample other than the one(s) authorized by me and my healthcare provider.

If I do not want to have any of my/my child's sample stored for future clinical testing that I request, I may initial here _____, and my/my child's sample will be destroyed at the end of the testing process or not more than 60 days after collection. I may withdraw this consent by contacting Sema4, including by emailing privacy@sema4.com.

De-identified research

Sema4 may de-identify and use all data and information generated and received in connection with this test to support medical and academic research relating to health, disease prevention, drug development, and other scientific purposes, and I will receive no compensation in connection with such research. Data and information are "de-identified" by removing any information that could be used to identify a specific person, such as a name, email address, or date of birth. Sema4 may also give the de-identified data and information to its research partners and may submit it to research databases for use in scientific and medical research, including scientific databases that are maintained by the federal government, such as a database kept by the National Institutes of Health ("NIH") (an agency of the federal government that funds research). Researchers have to apply to the NIH to see the information in the database.

If I do not want to have any of my/my child's de-identified data and information used in research consistent with this consent, I may initial here _____, I may withdraw this consent by contacting Sema4, including by emailing privacy@sema4.com.

Permission to contact

I understand that Sema4 may wish to contact me/my child in the future, including for the following reasons: research purposes, the provision of general information about research findings, and/or the provision of information about the results of tests on my/my child's sample(s). I understand that I may notify Sema4 to opt out of such future contact, including by emailing privacy@sema4.com.

The results of my/or my child's test will be explained to me by a genetic counselor or by my physician who will have the opportunity to discuss my results with a geneticist. I have had the opportunity to have all of my questions answered. If I am signing this form on behalf of a minor for whom I am the legal guardian, I am satisfied that I have received enough information to sign on his or her behalf.

I understand that this consent is being obtained in order to protect my right to have all of my questions answered before testing. I understand that the results of this testing will become part of my medical record and may only be disclosed to individuals who have legal access to this record or to individuals who I designate to receive this information.

Signature of person being tested (or guardian)

Date

Rev.01/17/20