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GENETIC TEST REQUEST FORM

HEMATO-ONCOLOGY

*MANDATORY FIELDS

ORDERING PHYSICIAN

PHYSICIAN'S NAME* | DEPARTMENT

INSTITUTION* | PHONE

EMAIL* | CITY | COUNTRY

PATIENT INFORMATION

NAME* | DATE OF BIRTH* (dd/mm/yyyy) | MEDICAL RECORD NO. | GENDER* ○ female ○ male

BILING INFORMATION (if receipt is issued on patient's behalf):

VAT No. | ADDRESS | ZIP CODE | CITY | COUNTRY

SAMPLE*

○ PERIPHERAL BLOOD ○ BONE MARROW ○ OTHER _____

COLLECTED AT | DATE AND TIME OF COLLECTION (dd/mm/yyyy) ___/___/___ ___:___

CLINICAL INFORMATION

1. DIAGNOSTIC HIPOTHESIS		
2. IN THERAPEUTICS	○ NO	○ YES
3. FOLLOW-UP	○ NO	○ YES
4. PREVIOUS TESTS	○ NO	○ YES

REQUESTED TEST*

*Please select at least **one** option*

CYTOGENETIC TESTS (collection in lithium heparin)

- ☐ Karyotype (non-stimulated cultures)
- ☐ Chromosomal breakage studies
- ☐ Karyotype (stimulated cultures)

FISH, please select rearrangement(s) to test:

- ☐ del(5q31)/(5q33)
- ☐ del(6q21)
- ☐ del(7q31)/-7
- ☐ trissomia 8
- ☐ trissomia 12
- ☐ del(13q14.3)
- ☐ del(13q34)
- ☐ del(20q12)
- ☐ *CKS1B/CDKN2C* (1q21.3/1p32.3)
- ☐ *BCL6* (3q27)
- ☐ *EGFR* del(5q31)
- ☐ *PDGFRB* (5q32)
- ☐ *cMYC* (8q24)
- ☐ *FGFR1* (8p11)
- ☐ *ATM* del(11q22.3)
- ☐ *KMT2A* (11q23)
- ☐ *IGH* (14q32)
- ☐ p53 del(17p13.1)
- ☐ *RARA* (17q21.2)
- ☐ *BCL2* (18q21)
- ☐ *MALT1* (18q21)
- ☐ *ALK* del(2p23);t(2;5)
- ☐ *RPN1/MECOM* (inv/t(3))
- ☐ t(4;14) *IGH/FGFR3*
- ☐ t(8;14) *MYC/IGH*
- ☐ t(8;21) *RUNX1/RUNX1T1*
- ☐ t(9;22) *BCR/ABL*
- ☐ t(11;14) *IGH/CCND1*
- ☐ t(11;18) *API2/MALT1*
- ☐ t(12;21) *ETV6/RUNX1*
- ☐ t(14;16) *IGH/MAF*
- ☐ t(14;18) *IGH/BCL2*
- ☐ t(14;18) *IGH/MALT1*
- ☐ t(15;17) *PML/RARA*
- ☐ inv(16)/t(16;16)
- ☐ t(17;22) *COL1A1/PDGFB*

FISH panels, please select a panel:

- ☐ OncoFISH for LLC – 4 probes: 13q-, 11q-, 17p-, +12
- ☐ OncoFISH for LLC – 5 probes: 13q-, 11q-, 17p-, +12, IGH
- ☐ OncoFISH for LMA – 7 probes: t(15;17), inv(16), t(8;21), 11q-, 5q-, 7q-, BCL6
- ☐ OncoFISH for MM – 4 probes: 13q-, 17p-, t(4;14), t(11;14)
- ☐ OncoFISH for SMD – 3 probes: 5q-, 7q-, 20q-
- ☐ OncoFISH for SMD – 4 probes: 5q-, 7q-, 20q-, cen8
- ☐ FISH for large B-cell LNH – t(14;18) and t(11;14)
- ☐ FISH for diffuse large B-cell LNH – t(14;18), t(8;14) and BCL6
- ☐ FISH for MALT LNH – t(14;18) and t(11;18)

MOLECULAR DIAGNOSTIC TESTS

Qualitative tests
2 to 5 mL PB/BM in PAXgene

- ☐ *AML-ETO*; t(8;21)
- ☐ *BCL1-IGH*; t(11;14)
- ☐ *BCL2-IGH*; t(14;18)
- ☐ *BCR-ABL*; t(9;22)
- ☐ *CALR* (exon 9)
- ☐ *CBFB-MYH11*; t/inv(16)
- ☐ *CEBPA*
- ☐ *E2A-PBX1*; t(1;19)
- ☐ *FIP1L1-PDGFRα*; del(4)(q12)
- ☐ *FLT3* (ITDs and point mutations)
- ☐ *JAK2* (exon 12)
- ☐ *JAK2* (V617F mutation)
- ☐ *MLL-AF4*; t(4;11)
- ☐ *MPL* (W515L/K mutations)
- ☐ *NPM1*
- ☐ *PML-RARα*; t(15;17)
- ☐ *TEL-AML1*; t(12;21)

Quantitative tests
10 mL PB in PAXgene

- ☐ *BCR-ABL* (p210)
- ☐ *TEL-AML1*
- ☐ *CBFB-MYH11*
- ☐ *PML-RARα*
- ☐ *AML1/ETO*

Clonal tests

- ☐ *IGH*
- ☐ *IGK*
- ☐ *TCRB*
- ☐ *TCRD*
- ☐ *TCRG*

Other hemato-oncology tests

- ☐ *BCR-ABL* Sequencing **(Imatinib resistance)**
- ☐ *BRAF* (V600 mutation)
- ☐ *c-KIT* sequencing
- ☐ Chimerism after BMT
  Requires collection of buccal cells and PB

For other genetic tests or sample requirements, please visit www.cgcgenetics.com

I certify that (i) the patient (or legal representative) has agreed to have this testing performed, by signing the patient informed consent, (ii) the patient informed consent is in agreement with the legal requirements and that (iii) I am providing CGC Genetics all relevant medical information indispensable for the testing to be performed.

I certify that (i) I was informed about the benefits, risks and limitations of the test to be performed, (ii) I put all the questions that I consider relevant and understood the answers provided. I give authorization to proceed with the requested genetic test and the use of the sample exclusively to this end.

○ **I agree** ○ **I do not agree**

The sample can also be used for scientific research purposes. ○ *I agree* ○ *I do not agree*

PHYSICIAN'S SIGNATURE _____
(mandatory)

Date: ___/___/___

PATIENT'S SIGNATURE _____
(to be used in case no other informed consent is available)

Date: ___/___/___

CLINICAL INFORMATION

LEGAL NOTICE

Test Procedure. To perform the genetic test a biological sample is required, such as peripheral blood or bone marrow. The sample(s) should then be sent to CGC Genetics, Rua de Sá da Bandeira, 706-1, 4000-432 Porto, Portugal. After the testing is performed, CGC Genetics will send the report with the results directly to your healthcare provider.

Test Limitations. Consult with your healthcare professional to learn more about the test, including its limitations and risks, detailed description of the tested genetic changes and what the result could mean to you. Medical counselling is recommended before and after testing is performed. The following limitations may be associated with hemato-oncology genetic test: 1) The laboratory may not be able to process the test if the sample is in poor condition or due to other technical problems that prevent conclusive result. In these situations, and whenever possible, CGC Genetics will contact the patient or responsible healthcare provider to address a possible alternative. 2) There is the possibility that a second sample may be requested due to insufficient material for a proper analysis or in a situation of discrepant results.

Privacy and test results. CGC Genetics is committed to ensure patient's data protection and confidentiality of all information originated during the whole process, according to the law. The result of your test will be directly sent to the requesting healthcare provider. Please request a copy of the test results directly to him/her. He/she is responsible for the interpretation and explanation of test results to you. CGC Genetics medical team is available to clarify your healthcare provider regarding any questions about your genetic test.

Patient rights. The patient can request the right of access, modification and cancellation of the data provided by letter addressed to CGC Genetics, Clinical Director to customercare@cgcgenetics.com.