REQUISITION FORM FOR GENETIC DIAGNOSTIC BRCA TESTING

GENOMED
Está nos genes.

REFERRING DOCTOR (MANDATORY):	
Name (or print label):	ID number:
Hospital:	Service:
E-mail:	Telephone:
Signature:	Date: _____/_____/_____

Do you authorize the report to be sent by e-mail? **Yes** ☐ **No** ☐ If yes, please indicate the **institutional e-mail address**: _____	*GenoMed use only:* Label *Verified by:* _____

PATIENT IDENTIFICATION (MANDATORY)	
Name (or print label):	Gender: F ☐ M ☐
Identification number: _____	Date of birth: _____/_____/_____

CLINICAL DATA AND DIAGNOSIS (we ask a pathology report whenever possible and applicable):

Affected ☐ **Not affected (asymptomatic)** ☐ **Ideal expected date:** _____/_____/_____

FAMILIAL INFORMATION

Index case (affected) ☐ **Familial variant** ☐

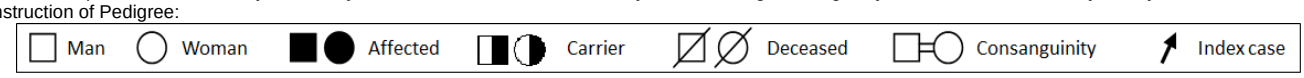
Known familial variant? NO ☐ YES ☐

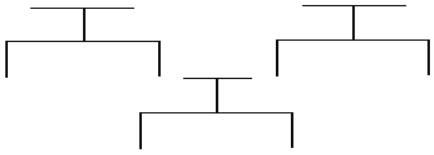
If yes*: Gene/RefSeq: _____/_____ Variant: _____

Was the index case studied at GenoMed? NO ☐ YES ☐

*For carrier studies and predictive testing (familial variant study), please attach a copy of the index case, whenever possible and applicable.
According with the Portuguese law, (article 9º, law nº 12/2005), carrier studies and predictive testing (conducted in healthy individuals) it is ESSENTIAL that the clinical geneticist makes the request and that the patient informed consent is obtained.

Attach whenever possible and can be justified any relevant clinical information, family data including consanguinity, other cases in the family, family tree, etc. Information for the construction of Pedigree:





Sample: Blood (EDTA) ☐ DNA ☐ FFPE (10 sections x 10µm) ☐ Other ☐	**Collection:** Date: ...../...../..... Time: .....
For somatic studies (in FFPE sample), we strongly recommend sending a blood sample together with the request.	

INFORMED CONSENT (to be filled by the referring doctor):

I hereby declare that patient informed consent for diagnosis was obtained.	YES ☐ NO ☐
I hereby declare that patient informed consent for investigation was obtained.	YES ☐ NO ☐

Signature of the referring doctor: **Date**:..... /...../.....

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	Available Tests	SNS Code (PT)
☐	**Pack 1:** *BRCA1* and *BRCA2* testing - index case Portuguese founder mutation (blood) + NGS (blood or FFPE) + MLPA (blood) *	34900
☐	**Pack 2:** *BRCA1* and *BRCA2* testing - index case Portuguese founder mutation (blood) + NGS (blood or FFPE) *	34900
☐	*BRCA1* testing - index case	34543
☐	*BRCA1* testing - familial case	34544
☐	Portuguese founder mutation *BRCA2* (insAlu) - index case	36061
☐	Portuguese founder mutation *BRCA2* (insAlu) - familial case	36062
☐	*BRCA2* testing - index case	34547
☐	*BRCA2* testing - familial case	34548
☐	*BRCA1*/*BRCA2* testing for CNVs - index case	36059
☐	*BRCA1*/*BRCA2* testing for CNVs - familial case	36060

*It includes testing for mutation origin (germline or somatic).
Note: somatic study, on FFPE sample, is only available for pack 1 and 2.

INFORMED CONSENT, according to the Direction of General Health updated standard 015/2013 (mandatory - to be filled by the patient):

I hereby declare that I have read the Privacy Policy of GenoMed® - Diagnósticos de Medicina Molecular, S.A., available at https://genomed.pt/en/privacy-and-cookies-policy/ and I give my consent to the processing of the personal data. ☐ Agree ☐ Not agree

Hereby I _____ [name], _____/_____/_____ [date of birth], give my consent that my / my child´s biological sample will be examined for genetic changes (mutations) in the specified gene(s), related to the diseases / clinical features described above. Herewith I declare that I have been informed about the chances and limitations of the requested testing procedure. I was informed in detail about the consequences resulting from the test results. I agree that the sample may be stored in order to allow repetition of the tests or further related tests in the future. All data about me / my child are subject to medical confidentiality. They can be disclosed to family members or their physicians only with my permission, but not to third parties. I am entitled to revoke this consent at any time. ☐ Agree ☐ Do not agree

I agree that my / my child´s tests results and/or clinical data may be used in scientific publications in anonymized form in case of approval of the Ethics Committee. ☐ Agree ☐ Do not agree

Patient's signature: _____ **Date:** _____/_____/_____

SAMPLE INFORMATION (FFPE) (REQUIRED FIELD) We ask a pathology report whenever possible, or the tumor cell percentage, for correctly interpret test results.

Sample characterization: Exam nº: _____ Resection/Biopsy Date: _____/_____/_____

☐ Sections **Macrodissection** ☐ Yes ☐ No **% Neoplastic Cells** _____

(If tumor cell percentage is lower than 20-30%, please use macrodissection to enrich the sample)

☐ FFPE block

Histology: ☐ Biopsy ☐ Needle biopsy ☐ Surgical piece

Contaminants:
☐ Epithelial cells ☐ Blood
☐ Mesenchymal cells ☐ Fibrin
☐ Inflammatory/immune response cells ☐ Mucus ☐ Other(s) _____

Pathology / Clinical Diagnosis / Relevant information about the sample:

Pathologist: _____ Hospital: _____

Direct contact (☎ or @): _____

Signature: _____

CONTACT PERSONS: Dr.ª Diana Antunes, MD (dianaantunes@medicina.ulisboa.pt) / Dr. Yuri Chiodo, PhD (ychiodo@medicina.ulisboa.pt) Ext. 47301/48308

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