87 Berdan Ave #4, Wayne NJ 07470
Phone: (973) 692-9780, Fax: (973) 832-7901

NOVALAB
Reference Medical Lab

CGx Requisition

PRIMARY PATIENT

LAST NAME	FIRST NAME	
DATE OF BIRTH (MM/DD/YYYY)	GENETIC SEX ◯ Male ◯ Female ◯ Unknown	
MED REC# / PATIENT IDENTIFIER	ETHNICITY	
ADDRESS		
CITY	STATE	POSTAL CODE
PHONE	EMAIL	
SAMPLE DRAW DATE (MM/DD/YYYY)	SAMPLE TYPE: ◯ Blood ◯ Buccal ◯ Other ◯ Extracted DNA & DNA Source: (Blood, Buccal, Tissue, Fibroblast)	

I have read the Informed Consent document and I give permission to Novalab Corp to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at Novalab and fir publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications.

☐ Opt out of research

☐ Check this box if you are a New York state resident and give permission for Novalab to retain any remaining sample longer than 60 days after the completion of testing

PATIENT SIGNATURE (REQUIRED FOR BILLING PURPOSES) X	DATE (MM/DD/YYYY)

ORDER PROVIDER

INSTITUTION / PRACTICE NAME	INSTITUTION PHONE / FAX / EMAIL	
PROVIDER LAST NAME	PROVIDER FIRST NAME	
NPI (USA)	PROVIDER TITLE (MD, DO, GC)	
PROVIDER ADDRESS		
CITY	STATE	POSTAL CODE
PROVIDER PHONE	FAX REPORT TO	
GC / PRIMARY CONTACT	GC/PRIMARY CONTACT PH/EMAIL/FAX	

I attest that the patient had received and read the Novalab Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose,capabilities, and limitations of the ordered test. The patient has voluntarly given his or her full consent for the ordered test and a signed copy of this consent is available on the file. Any Novalab Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent

STATEMENT OF MEDICAL NECESSITY
By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

ORDERING PROVIDER SIGNATURE (REQUIRED) X	DATE (MM/DD/YYYY)

TEST REQUESTED

TEST NAME

- ◯ CGx Comprehensive Cancer Panel — 44 genes
- ◯ CGx Breast Cancer Panel — 12 genes
- ◯ CGx Lynch Syndrome Panel — 5 genes
- ◯ CGx Pancreatic Cancer Panel — 14 genes
- ◯ CGx Colorectal Cancer Panel — 14 genes
- ◯ CGx Ovarial Cancer Panel — 17 genes
- ◯ CGx Uterine Cancer Panel — 8 genes

TEST OPTIONS
Omitted test options will default to Seq & Del/Dup

◯ Seq & Del / Dup

☐ Exclude VUS

INDICATIONS FOR TESTING
Check all that apply

☐ Diagnostic
☐ Presymptomatic
☐ Family History
☐ Family Variant
☐ Other:

CLINICAL DETAILS

☐ No personal history of cancer

Cancer/Tumer Type	Onset Age	Details	Cancer / Tumer Type	Onset Age	Details
☐ Breast			☐ Ovarian		
☐ Colorectal			☐ Other cancer		

FAMILY HISTORY

Attach pedigree and additional pages as needed

FAMILY MEMBER 1 NAME	RELATION TO PATIENT	GENETIC SEX ◯ Male ◯ Female ◯ Unknown	
DIAGNOSE AND/OR SYMPTOMS		AGE OF ONSET	DOB (MM/DD/YYYY)
FAMILY MEMBER 2 NAME	RELATION TO PATIENT	GENETIC SEX ◯ Male ◯ Female ◯ Unknown	
DIAGNOSE AND/OR SYMPTOMS		AGE OF ONSET	DOB (MM/DD/YYYY)
FAMILY MEMBER 3 NAME	RELATION TO PATIENT	GENETIC SEX ◯ Male ◯ Female ◯ Unknown	
DIAGNOSE AND/OR SYMPTOMS		AGE OF ONSET	DOB (MM/DD/YYYY)