PRIMEX Clinical Laboratories, Inc.

BRCA Questionnaire

Patient Information

Name:_____

DOB: _____ Gender: M F

Phone #: _____

Patient History

History of BRCA Testing? Circle One:

No Hx of testing Negative BRCA 1/2

Positive: BRCA 1 BRCA 2

Any History of Cancer? No Yes (If yes explain below)

Cancer Site	Age at Dx:	Check all that apply:
Breast: ☐ IDC		☐ Bilateral
☐ ILC		☐ Premenopausal
☐ DCIS		☐ Triple Negative (ER, PR, HER2)
☐ LCIS		
Ovarian ☐		
Other (please specify):		

Family History

Any family history of BRCA gene mutation? Circle One: No Yes BRCA 1 BRCA 2

Any family history of cancer? No Yes (If yes explain below)

Relationship	Cancer Type	Age at Dx	Maternal or Paternal

Patient Acknowledgment

By signing below, patient has been informed that BRCA testing is medically necessary. This does not guarantee testing is covered by the patient's insurance company and does not guarantee payment for testing. Patient understands they are responsible for any amount not covered by their health plan.

Patient's Signature: _____ Date: _____

Provider Information

Provider's Name: _____

Provider's Client #:_____ Provider's Phone #:_____

Provider's Confirmation of Informed Consent and Medical Necessity

By signing below, the provider ordering BRCA testing on the above named patient confirms that testing is medically necessary. The provider acknowledges the patient has been informed about the purpose of this genetic test. The provider further acknowledges the patient is aware there may be out-of-pocket expenses that may not be covered by their current health plan and the patient has given testing consent by signing above.

Provider's Signature: _____ Date: _____