Revive Genetics Diagnostics Laboratory

CLIA: 10D2337214

Familial Cancer (CGX) Panel

Requisition & Consent Form

Patient Information

Last Name	First Name	DOB	Sex	MRN

Address	City	State	Zip	Phone Number

Email

Ethnicity ☐ African American ☐ Ashkenazi Jewish ☐ East Asian ☐ Hispanic ☐ Middle Eastern ☐ White ☐ Other

Insurance/Billing Information

Insurance Name	Member ID	Group ID

Primary Name	Primary DOB	Relationship
		☐ Self ☐ Spouse ☐ Child

Ordering Provider/ Facility

Provider Name	NPI	Facility Name	Email

Address	City	State	Zip	Phone Number

Specimen Information

Specimen Type

Collector Name	Collection Date/ Time	Collection Site
		☐ Office ☐ Lab ☐ Home ☐ Other

Confirmation of Medical Necessity for Genetic Testing

I certify that I am a licensed healthcare provider (or authorized representative/genetic counselor) ordering genetic testing. I confirm that the patient has been informed of the purpose, scope, limitations, and potential risks of this testing, has had the opportunity to ask questions and seek genetic counseling, and has provided informed consent, which is on file. I attest that this testing is medically necessary and will be used in the clinical management of the patient. I further confirm that the patient authorizes **Revive Genetics** to release relevant information to third-party payors for reimbursement purposes, to receive direct payment for services rendered, and, where applicable, to act as the patient's designated representative for insurance appeals. I acknowledge that the patient understands and accepts financial responsibility for any amounts not covered by insurance, including payments made directly to the patient.

Medical Professional Signature: _____ **Date:** _____

Print Name: _____

Website www.revivegenetics.us **Email** info@revivegenetics.us	**Address** 9000 SW 152nd St Suite107, Palmetto Bay, FL 33157	**Lab Director** Uzma Farooq, MD	**Phone Number** 786-250-3419

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Test Selection

Select	Panel	Genes	Brief Description
	Express Gene™ Comprehensive Familial Cancer (CGX) Panel	193 Genes	Identifies inherited genetic variants associated with hereditary cancer predisposition by evaluating genes involved in DNA repair, tumor suppression, cell cycle regulation, and genomic stability.

Indications for Testing (Check All That Apply)

☐ Diagnostics ☐ Family History ☐ Recurrent or Unexplained Infections ☐ Patient Management

Clinical Information

Genetic Testing Done Previously: ☐ Yes ☐ No	If Yes what test:	Date of Previous Test: ____/____/____

The panel includes all genes listed below. If only specific gene(s) are requested, please select them below. For the complete list of genes included in each subpanel, please refer to our company's website:

ABL1, ABL2, ABRAXAS1, ACVR1B, AIP, AKT1, ALK, ANKRD26, APC, ARMC5, ASXL1, ATM, ATR, AXIN2, BAP1, BARD1, BLM, BMPR1A, BRAF, BRCA1, BRCA2, BRIP1, BUB1B, CASR, CBFB, CBL, CCND1, CDC73, CDH1, CDK4, CDKN1B, CDKN1C, CDKN2A, CEBPA, CHEK2, CHIC2, CPA1, CREBBP, CTC1, CTNNA1, CTNNB1, CYLD, DDB2, DDX41, DICER1, DIS3L2, DKC1, EGFR, EGLN1, EP300, EPCAM, ERBB2, ERCC1, ERCC2, ERCC3, ERCC4, ERCC5, ESR1, ETV6, EXT1, EXT2, EZH2, FAN1, FANCA, FANCB, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, FANCM, FGFR1, FGFR3, FGFR4, FH, FLCN, FLT3, FLT4, GALNT12, GATA2, GPC3, GREM1, HNF1A, HOXB13, HRAS, IDH1, JAK1, KIF1B, KIT, KRAS, LZTR1, MAP2K4, MAX, MC1R, MEN1, MET, MIR142, MITF, MLH1, MLH3, MPL, MRE11, MSH2, MSH3, MSH6, MST1R, MUTYH, MYC, NBN, NF1, NF2, NHP2, NOP10, NPM1, NRAS, NSD1, NTHL1, PALB2, PALLD, PBRM1, PDGFRA, PDGFRB, PHOX2B, PIK3CA, PMS2, POLD1, POLE, POLH, POT1, PRF1, PRKAR1A, PRSS1, PTCH1, PTCH2, PTEN, PTPN11, RAD50, RAD51C, RAD51D, RARA, RARG, RB1, RECQL, RECQL4, REST, RET, RHBDF2, RPL5, RPS20, RUNX1, SAMD9L, SBDS, SCG5, SDHA, SDHAF2, SDHB, SDHC, SDHD, SF3B1, SLC45A2, SLX4, SMAD4, SMARCA4, SMARCB1, SMARCE1, SMO, SOS1, SRC, SRP72, STK11, SUFU, TERC, TERT, TET2, TGFBR2, TINF2, TLR4, TMEM127, TP53, TRIP13, TSC1, TSC2, TYR, U2AF1, VHL, WRAP53, WRN, WT1, XPA, XPC, XRCC2

List relevant family history of disease (affected family members and relationship to patient):

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Informed Consent

Consent to Testing and Use of Results
I confirm that the submitted specimen belongs to the identified patient and has been voluntarily provided for analysis by **Revive Genetics**. I authorize the laboratory and my healthcare provider to analyze my clinical and genetic information, perform the ordered hereditary cancer genetic testing, release test results to the ordering healthcare provider, and disclose information necessary for billing and reimbursement to my insurance carrier, when applicable.

Consent for Hereditary Cancer Genetic Testing
Your healthcare provider has ordered a **Comprehensive Familial Cancer (CGX) Genetic Panel** to evaluate genes associated with inherited cancer predisposition syndromes. This test analyzes genes involved in DNA repair, tumor suppression, cell cycle regulation, genomic stability, and other biological pathways that help protect against the development of cancer.
Depending on your personal and family history, this evaluation may help identify inherited genetic variants associated with an increased risk of hereditary cancers, including breast, ovarian, colorectal, prostate, pancreatic, endometrial, melanoma, endocrine, gastrointestinal, and other hereditary cancer syndromes.
Genetic testing may identify disease-causing (pathogenic) variants, likely pathogenic variants, variants of uncertain significance (VUS), or no clinically significant findings. A positive result may help confirm an inherited cancer predisposition, guide cancer screening and prevention strategies, assist with treatment decisions, identify at-risk family members, and provide information regarding inherited cancer risk. However, a positive result does not predict whether cancer will develop, the age of onset, the specific type of cancer, or disease severity. Likewise, a negative result does not eliminate the possibility of hereditary cancer risk or future cancer development.

Please be aware of the following limitations:
This test analyzes only the genes included in the selected panel.
Some genetic changes, including deep intronic variants, balanced chromosomal rearrangements, epigenetic alterations, repeat expansions (unless specifically included), low-level mosaicism, structural variants, mitochondrial variants (unless specifically included), or variants in genes not included on the panel, may not be detected.
Not all hereditary cancer susceptibility genes have been identified, and some inherited cancer risks may not be detectable with current technology.
Variants of Uncertain Significance (VUS) may be identified. These findings currently have insufficient evidence to determine whether they are disease-causing and should not be used alone for medical decision-making.
Genetic test results should always be interpreted together with your personal medical history, family history, physical examination, pathology findings, laboratory studies, imaging results, and other clinical information.
Additional testing, including deletion/duplication analysis, tumor molecular profiling, chromosomal analysis, or broader genomic testing such as whole exome or whole genome sequencing, may be recommended based on your clinical presentation and family history.
Genetic counseling is strongly recommended before and/or after testing to discuss the potential benefits, limitations, implications for medical management, and the potential impact of results on biological relatives.

By signing this consent form, you acknowledge that:
You understand the purpose, benefits, and limitations of hereditary cancer genetic testing.
You understand that testing may identify inherited genetic variants that have implications for your biological relatives.
You understand that results may identify unexpected or uncertain findings that could require additional medical evaluation or surveillance.
You understand that your results will be reviewed by your ordering healthcare provider and may be discussed with you by your physician or a qualified genetics professional.
You voluntarily consent to undergo the requested genetic testing.

Methodology Limitations
Next-generation sequencing (NGS) has inherent technical limitations. Certain types of genetic variants may not be detected by this methodology, including some structural rearrangements, repeat expansions (unless specifically included in the assay), low-level mosaic variants, or variants located in genomic regions with limited sequencing coverage.
Testing is limited to the genes and variant types validated for the ordered assay.
All test results are treated as confidential and are released only to the patient, the ordering healthcare provider, and other individuals authorized by the patient or required by law. No tests other than those authorized will be performed. Patient specimens will be retained for up to **60 days** following completion of testing and then destroyed according to laboratory policy unless otherwise required.
I have read this consent form, or it has been read to me. I have received satisfactory answers to my questions and understand that I may ask additional questions at any time. I voluntarily consent to the requested genetic test.

Consent / Insurance Release
By signing this form, I authorize **Revive Genetics** to submit medical information related to this testing to my designated insurance carrier for reimbursement when necessary. I authorize payment of benefits directly to **Revive Genetics**. I understand that I am responsible for any charges not covered by my insurance, including but not limited to non-covered, non-authorized, or denied services. I authorize a copy of this authorization to be used in place of the original.

Patient or Parent/Guardian Signature: _____ **Date:** _____

Print Name: _____

Optional Consent for Research and Future Contact
To improve genetic testing and advance the understanding of hereditary cancer syndromes and inherited cancer predisposition, I voluntarily authorize **Revive Genetics** to use any remaining specimen, de-identified genetic data, and/or clinical information for research, educational, quality improvement, or laboratory development purposes. My identity will not be disclosed in any publication or research activity.
I also authorize **Revive Genetics** to contact me in the future regarding newly discovered disease-associated genes, updated variant classifications, research opportunities, or clinically relevant follow-up related to my testing.
Participation is voluntary and declining this consent will not affect the performance of my ordered test or my medical care.

Patient or Parent/Guardian Signature: _____ **Date:** _____

Print Name: _____

Medical Professional Signature: _____ **Date:** _____

Print Name: _____

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