A test that provides cancer risk for all

CE IVD

MyRisk® Plus

Hereditary Cancer Test

Myriad genetics

Myriad Genetic Laboratories, Inc.
320 Wakara Way - Salt Lake City, Utah 84108
PH: +1 (877) 283-6709 - FX: +1 (801) 883-8998
www.myriad.com
Outside U.S.A
Email: CustomerSupport@myriadgenetics.eu

EC REP

Myriad International GmbH
Nattermannallee 1
50829 Cologne, Germany

Affix one bar code label here

Test Request Form

- To avoid delays please complete entire form
- Please print all information in BLOCK LETTERS

Specimen collection date (required): (DD-MMM-YYYY) ☐☐ ☐☐☐ ☐☐☐☐

Specimen collected by (required)

Patient

Date of birth (DD-MMM-YYYY): ☐☐ ☐☐☐ ☐☐☐☐	
Gender: ☐ Female ☐ Male	Patient ID:
Last name:	
First name:	

Billing information

Payor ID: _____
or
research #: _____
or
voucher #: _____

Ordering physician

Last name:	Degree:
First name:	Clinical ID:
Institution:	
Street, nr:	
City, postal code:	Day phone:
Country:	Fax:
E-mail: _____	

Send results to (Optional – additional clinician can be listed to receive status updates and the patient's copy of the results)

Last name:	First name:	Institution:	
Street, nr:	City, postal code:	Country:	E-mail:

Test requested

MIL_MyRisk - Myriad Genetics MyRisk® Plus is a next generation sequencing based in vitro diagnostic device that provides sequencing and large rearrangement analyses for the qualitative detection and classification of variants on a panel of genes related to hereditary cancer using genomic DNA from peripheral blood, saliva, and fibroblast specimens. MyRisk Plus may be used as a companion diagnostic to identify patients who are or may become eligible for treatment with specific therapies in accordance with the approved therapeutic product labeling. In addition, polygenic risk score analysis is performed and reported for eligible patients. Results of these analyses are to be used by qualified health care professionals in accordance with professional guidelines.

Risk analysis options (tick to exclude from report):
☐ Do not include RiskScore®
☐ Do not include RiskScore® or Tyrer-Cuzick

Ancestry (Select all that apply)

☐ Ashkenazi Jewish ☐ Black / African ☐ Middle Eastern ☐ Pacific Islander
☐ Asian ☐ Hispanic / Latino ☐ Native American ☐ White / Non-Hispanic

Turn the page for additional patient information, test selection and authorized signature.

A test that provides cancer risk for all

CE IVD

MyRisk® Plus
Hereditary Cancer Test

Myriad genetics

Test Request Form

- To avoid delays please complete entire form
- Please print all information in BLOCK LETTERS

Patient personal history of cancer and other clinical information (Select all that apply)

☐ No personal history of cancer

Patient has been diagnosed with:		Age at diagnosis	Patient is currently being treated	Pathology / Other Info
☐ Breast cancer	☐ Left ☐ Right		☐	☐ Ductal invasive ☐ Lobular invasive ☐ DCIS ☐ Metastatic ☐ Bilateral ☐ Premenopausal ☐ Triple negative (ER-, PR-, HER2-)
☐ Endometrial / Uterine cancer			☐	☐ Tumor MSI-High or IHC Abnormal - Result _____ ☐ Tumor not available for MSI-High or IHC Abnormal testing
☐ Ovarian cancer			☐	☐ Non-epithelial
☐ Prostate cancer			☐	Gleason Score _____ ☐ Metastatic
☐ Colon / Rectal cancer			☐	Type: ☐ Mucinous ☐ Signet ring ☐ Medullary growth pattern ☐ Tumor infiltrating lymphocytes ☐ Crohn's-like lymphocytic reaction ☐ Patient's tumor is MSI-High or IHC abnormal - Result _____ ☐ Tumor not available for MSI-High or IHC abnormal testing
☐ Colon / Rectal adenomas			☐	☐ Known Familial Adenomatous Polyposis (FAP) Cumulative Adenomatous Polyp #: ☐ 1 ☐ 2-5 ☐ 6-9 ☐ 10-19 ☐ 20-99 ☐ 100+
☐ Hematologic cancer			☐	
☐ Other cancer(s) (e.g. cancers of the stomach, pancreas, bile duct, kidney, ureter, brain, skin and others)			☐	Type: _____
Check if applicable to patient:		___% on one of the Lynch Syndrome Risk Models (PREMM$_5$, MMRpro, or MMRpredict)		
		☐ Bone Marrow transplant recipient Type: ☐ Autologous ☐ Allogeneic (if allogeneic please contact **helpmed@myriadgenetics.eu**)		
		☐ Blood transfusion recipient within 28 days of sample collection Type: ☐ Whole blood ☐ Packed red blood cells ☐ Blood transfusion recipient within 12 months of sample collection Date: (DD-MMM-YYYY) ☐☐ ☐☐☐ ☐☐☐☐		

Family history of cancer

☐ No known family history of cancer

Relationship to patient	Maternal (mother's side)	Paternal (father's side)	Cancer site	Age at each diagnosis
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

The MyRisk Plus Management Tool and RiskScore™ may not be reported without an accurate and specific personal and family history included.

Breast cancer risk model information

Height (cm):_____ **Weight** (kg):_____

Age at time of first menstrual period: _____

Is patient currently: ☐ Pre-Menopausal ☐ Peri-Menopausal ☐ Post-menopausal **Age of post-menopausal onset** _____

Has this patient had a live birth? ☐ No ☐ Yes: **patient's age at first child birth:** _____

Has patient ever used hormone replacement therapy? ☐ No ☐ Yes
If yes, treatment type: ☐ Combined ☐ Estrogen only ☐ Progesterone only
If yes, is patient a: ☐ **Current user:** Started _____ years ago
Intended use for_____ more years
☐ **Past user:** Stopped _____ years ago

Information about patient's female relatives:

Number of daughters: ____

Number of sisters: _____

Number of maternal aunts (mother's sisters): _____

Number of paternal aunts (father's sisters): _____

Other information:

Mammographic density:

Has the patient had her breast density assessed? ☐ No ☐ Yes
If yes, complete one of the following for the most recent assessment:
☐ Volpara® volumetric density: _____ %
☐ VAS percentage density: _____ %
☐ BI-RADS® ATLAS density (Select one of the following):
☐ Almost entirely fatty ☐ Heterogeneously dense
☐ Scattered fibroglandular density ☐ Extremely dense ☐ Unknown

NOTE: Risk associated with mammographic density is not incorporated into RiskScore (v.1), nor Tyrer-Cuzick (v.7) calculations provided on the clinical report.

Please indicate if the patient has had a breast biopsy showing one or more of the following results: ☐ N/A (No biopsy or none of the listed results)
☐ Hyperplasia ☐ Atypical hyperplasia ☐ LCIS ☐ Biopsy with unknown or pending results

Authorized signature (Physician / healthcare provider)

I hereby authorize testing and confirm that informed consent has been obtained from the patient for blood or saliva to be sent to Myriad for analysis. I confirm that this test is medically necessary and results will be used in the medical management and treatment decisions for the patient. I hereby declare that the clinical information described on this Test Request Form is correct and belongs to the patient mentioned above. I hereby attest that the person listed in the ordering physician space above is authorized by law in the relevant jurisdiction to order the test requested herein.

Date (DD-MMM-YYYY) ☐☐ ☐☐☐ ☐☐☐☐

_____
Ordering physician / healthcare provider's signature

(Signature date is the specimen collection date if a different date is not provided above)

Internal use only: Bill Institution BIE _____ .

If previous genetic testing of one of the requested genes has been performed on this patient or a family member, the ordering physician or health care provider should inform the laboratory within two (2) business days of sending the specimen.

For information or questions regarding Myriad's privacy policy and technical specifications please visit our website: http://www.myriadgenetics.eu