eurofins | Biomnis

Test request form
Oncogenetics - Hereditary predisposition to the occurrence of cancer

INTERNATIONAL DIVISION
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E-mail: **international@eurofins-biomnis.com**

Invoicing	Customer No	Your references in case of exome request
☑ Laboratory		

Nota Bene : These tests should be ordered during a dedicated consultation by an oncogeneticist, a genetic counsellor in conjunction with an oncogenetic team or a specialist doctor with oncogenetic expertise.

Please enclose the consultation certificate and the completed consent form with the request.

In case of an urgent request, please contact the international division.

YOUR TEST REQUEST

- **Whole Exome Sequencing with CNV detection (including the genes in the panels listed below)**
  Test code EXONC

1 | Type of exome and interpretation method

☐ Exome_Diag_Premium	with interpretation + access to the SeqOne interface
☐ Exome_Diag	with interpretation
☐ Exome_Seq_Premium	raw data + access to the SeqOne interface
☐ Exome_Seq	raw data

2 | Strategy

☐ Solo
☐ Other strategy (Duo, Trio), specify:

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- **Gene panels with CNV detection**

☐ **Breast/Ovary and Prostate panel** (15 genes including the 13 HBOC genes recommended by the GGC*: *ATM, BRCA1, BRCA2, CDH1, EPCAM, HOXB13, MLH1, MSH2, MSH6, PALB2, PMS2, PTEN, RAD51C, RAD51D, TP53*)
Test code EOSOP

☐ **Digestive Tube Panel** (14 genes recommended by the GGC*: *APC, BMPR1A, CDH1, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, POLD1, POLE, PTEN, SMAD4, STK11*)
Test code EODIG

☐ **Pancreas panel** (16 genes: *APC, ATM, BRCA1, BRCA2, CDK4, CDKN2A, EPCAM, MEN1, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53, VHL*)
Test code EOPAN

☐ **Kidney panel** (20 genes: *BAP1, CDKN2B, FH, FLCN, HNF1B, MET, MITF, PBRM1, PTEN, SDHA, SDHAF2, SDHB, SDHC, SDHD, SETD2, TMEM127, TSC1, TSC2, VHL, WT1*)
Test code EOREI

☐ **Skin panel** (16 genes: *ACD, BAP1, CDK4, CDKN2A, FLCN, MC1R, MITF, NF1, POLE, POT1, PTCH1, PTCH2, RAD51B, SUFU, TERF2IP, TERT*)
Test code EOPEA

☐ **Lung panel** (15 genes : *ATM, BAP1, BRCA1, BRCA2, CDKN2A, CHEK2, EGFR, ERBB2, MET, NBN, PRKN, RTEL1, STN1, TP53, VHL*)
Test code EOPOU

☐ **Neuroendocrine panel** (28 genes: *DLST, DNMT3A, EGLN1, EGLN2, EPAS1, FH, GOT2, LZTR1, MAX, MDH2, MEN1, MERTK, MET, NF1, NF2, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, SLC25A11, SMARCB1, TMEM127, TP53, TSC1, TSC2, VHL*)
Test code EONEN

☐ **Extended oncogenetic panel including breast/ovary and prostate, digestive, pancreatic, kidney, skin, lung and neuroendocrine panels** (75 genes: *ACD, APC, ATM, BAP1, BMPR1A, BRCA1, BRCA2, CDH1, CDK4, CDKN2A, CDKN2B, CHEK2, DLST, DNMT3A, EGFR, EGLN1, EGLN2, EPAS1, EPCAM, ERBB2, FH, FLCN, GOT2, HNF1B, HOXB13, LZTR1, MAX, MC1R, MDH2, MEN1, MERTK, MET, MITF, MLH1, MSH2, MSH6, MUTYH, NBN, NF1, NF2, PALB2, PBRM1, PMS2, POLD1, POLE, POT1, PRKN, PTCH1, PTCH2, PTEN, RAD51B, RAD51C, RAD51D, RET, RTEL1, SDHA, SDHAF2, SDHB, SDHC, SDHD, SETD2, SLC25A11, SMAD4, SMARCB1, STK11, STN1, SUFU, TERF2IP, TERT, TMEM127, TP53, TSC1, TSC2, VHL, WT1*)
Test code EOETE

☐ **Retinoblastoma** (RB1 gene study, subcontracted to a reference centre)
Test code CUR10

**GGC : Groupe Génétique et Cancer - French Genetics and Cancer Group*

B67-INTGB - March 2022

- **Targeted test:** ☐ **Sanger sequencing - Test code SEPOS** ☐ **qPCR - Test code QPOST**

  ☐ in an index case for confirmation of a positive result (2nd sample)

  ☐ in a relative for family investigation (1st sample) if the index case was tested in our laboratory

  ☐ in a relative for confirmation of a positive result (2nd sample) if the index case was tested in our laboratory

  For targeted Sanger or qPCR techniques : attach information form R66-INTGB

- ☐ **"Reinterpretation" or "Filters opening" of an analysis already performed in our laboratory - Test code REINT**

  Precise the file number: ____

REFERRING PHYSICIAN

Last name: ..... First name: .....

Address: .....

Postcode: ⌊_⌊_⌊_⌊_⌊_⌋ City: .....

Email: .....

Tel.: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋ Fax: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋

Physician's stamp

PATIENT (INDEX CASE)

Last name: ..... First name: .....

Birth name: .....

Date of birth: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌊_⌊_⌋ Gender: ☐ F ☐ M

Date of sampling: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋ **Type of sample:** .....

INFORMATION CONCERNING BLOOD RELATIVES (IN CASE OF DUO/TRIO QUATUOR EXOME)

BLOOD RELATIVE 1 | Last name: ..... First name: .....

Date of birth: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌊_⌊_⌋ Gender: ☐ F ☐ M Relationship with the index case: .....

Date of sampling: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋ **Type of sample:** .....

☐ Sample included with index case sample

☐ Sample not taken from blood relative / Sample not sent alongside index case sample

BLOOD RELATIVE 2 | Last name: ..... First name: .....

Date of birth: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌊_⌊_⌋ Gender: ☐ F ☐ M Relationship with the index case: .....

Date of sampling: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋ **Type of sample:** .....

☐ Sample included with index case sample

☐ Sample not taken from blood relative / Sample not sent alongside index case sample

ADDITIONAL BLOOD RELATIVE | Last name: ..... First name: .....

Date of birth: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌊_⌊_⌋ Gender: ☐ F ☐ M Relationship with the index case: .....

Date of sampling: ⌊_⌊_⌋⌊_⌊_⌋⌊_⌊_⌋ **Type of sample:** .....

☐ Sample included with index case sample

☐ Sample not taken from blood relative / Sample not sent alongside index case sample

INDICATION

Family tree

Geographical origin*: .....
*(*The frequency and distribution of genetic mutations differs according to the ethnic/geographical origins of the patient)*

Consanguinity: ☐ YES *(please indicate on the family tree)* ☐ NO

Please provide a detailed clinical report for the patient and his/her medical history.

Detailed clinical information is essential for accurately interpreting results.

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CLINICAL INFORMATION

Type(s) of cancer and age of onset: .....

Other clinical signs: .....

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ADDITIONAL ANALYSES CARRIED OUT

(somatic analysis of the tumour, genes already studied, immunohistochemistry, MSI status, HRD (Homologuous Recombination Deficiency / BRCAness), chromosomal analysis by DNA chip, imaging ...)

☐ YES ☐ NO

Please specify the type of analysis / genes and the results obtained or attach a results report.

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Declaration of genetic consultation and informed consent

INTERNATIONAL DIVISION Tel: **+33 (0)4 72 80 23 85** • Fax: **+33 (0)4 72 80 73 56**
Email: **international@eurofins-biomnis.com**

CONSENT FOR THE GENETIC CHARACTERISTICS TEST ON AN INDIVIDUAL AND THE PRESERVATION OF SAMPLES.

Patient information Last name: .....First name: .....
Date of birth: |__|__| |__|__| |__|__|__|__|

Legal representative(s) information
(as appropriate) Last name: .....First name: .....
(as appropriate) Last name: .....First name: .....

I, the undersigned, declare that I have been informed by:

☐ Dr .....

☐ Genetic Counsellor ..... under the responsibility of Dr .....
and on their behalf

about the genetic characteristics test which will conducted on a sample/samples taken from:

☐ Myself
☐ My child or an adult under my guardianship

For: *(mandatory statement of the name of the pathology or name of the test conducted according to an aetiological, predictive or healthy carrier diagnosis)*

.....

ACKNOWLEDGEMENT OF THE FOLLOWING INFORMATION:

I declare that I have received the information needed to understand this test and its purpose.
I consent to this test being performed.

The results of the test will be provided to me and explained based on the current state of knowledge by the doctor/genetic counsellor who prescribed it as part of an individual consultation. The doctor/genetic counsellor will explain the necessary treatment methods where appropriate.

I understand that if a genetic abnormality that could be responsible for a predisposition or a serious affliction is identified, I must allow this information to be passed on to the rest of my/their family. I have been warned that remaining silent could pose a risk to them and their descendants, where preventive measures, including genetic counselling or treatment, could be proposed. I can either share this genetic information with members of my/their family myself, or permit the prescribing physician to do so.

I authorise, in compliance with medical confidentiality: The transmission of information from my/their medical file to the doctors involved with this test.

I acknowledge that my/the personal data relevant for making a diagnosis and the results report for my/their test will be kept, in paper form or in a digital database, by the prescribing physician and the medical biology laboratory authorised to conduct this test, in accordance with the regulations in force.

I have been informed that, in accordance with the current laws, my/their sample will be destroyed once the legal retention period has expired or, unless requested otherwise by myself in writing sent to the Eurofins Biomnis administrative office, used and transferred, anonymously and according to medical confidentiality, for scientific or quality control purposes.

In addition, cross out any of the following paragraphs that you disagree with:

* I wish to be informed of the results of the test conducted.
* Genetic information not directly linked to my/their pathology but which may have an impact on my/their care and/or treatment or that of my/their relatives may be disclosed. I wish for this information to be disclosed to me:
  ☐ YES ☐ NO ☐ Not applicable
* I agree for the transmission and use of my/their results for the genetic analysis of other members of my family who may wish for a consultation.
* I agree for a sample of a biological material from me/them to be kept and used at a later date to continue the investigation as part of this diagnostic approach, according to developments in medical knowledge.

Signed in..... ,
On |__|__| |__|__| |__|__|

Signature of the patient or legal representative(s) for a minor or adult under guardianship

REFERRING PHYSICIAN DECLARATION OF CONSULTATION**

I certify that I have informed the patient named above or their legal representative of the characteristics of the disease being tested for, the means for identifying it, the reliability of the analyses, options for prevention and treatment and how the disease in question can be transmitted genetically, along with its potential consequences for other members of the family.
I certify that I have received the consent of the patient named above or their legal representative according to the conditions laid down in the regulations in force.

Signed in ..... on .....

Signature and stamp

***REMINDER OF THE REGULATIONS**

***The referring physician** must keep:*

- *The written consent*
- *Duplicates of the prescription and declaration*
- *The reports of medical biology analyses with discussion and which have been signed (Art. R1131-5).*

***The authorised laboratory** conducting the tests must:*

- *Ensure that there is a prescription, referring physician declaration and written consent from the patient*
- *Send, to the referring physician, who alone is authorised to communicate the results to the individual concerned, the medical biology analysis report with discussion and which is signed by an approved practitioner*
- *Send, where appropriate, to the laboratory that transmitted the sample and was involved in the analysis, the medical biology analysis report with discussion and which is signed by an approved practitioner*

Law no. 2011-814 of 7 July 2011 *on bioethics*

Order of 27 May 2013 *defining the rules of good practice applicable to the genetic characteristics test on an individual for medical purposes*

Decree no. 2013-527 of 20 June 2013 *on the conditions for informing biological relative in relation to genetic characteristics tests for medical purposes*

Decree no. 2008-321 of 4 April 2008 *on genetic characteristics tests on an individual or their identification via genetic fingerprinting for medical purposes.*

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