**Family & Clinical History Information Form**

Dear Healthcare Provider: This Ancestry Form should be submitted with your patients completed Test Requisition form. Please provide the Family and Patient History information requested below. This information is necessary for verification of test propriety and to file appropriately for reimbursement of testing fees. Please complete, sign, and fax the form to 203-789-9100 or mail to Mira Dx at the address listed below. Thank you. **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BRCA Tested: Yes  No  If yes, please provide results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Intact Ovaries: Yes  No **

 **PATIENT HISTORY FAMILY HISTORY**

|  |  |
| --- | --- |
|  None (No Personal History) Breast, Invasive / Age @ Diagnosis \_\_\_\_\_\_\_\_ Triple Negative Breast (ER-negative PR-negative HER2/neu-negative) Breast, IN SITU / Age @ Diagnosis \_\_\_\_\_\_\_\_\_ Ovary / Age @ Diagnosis \_\_\_\_\_\_\_\_\_ Lung Cancer (NSCLC)/ Age @ Diagnosis \_\_\_\_\_\_\_\_\_ Colon, Adenoma (Polyp) / Age @ 1st Diagnosis \_\_\_\_\_\_\_\_\_\_# of Adenomas to date: \_\_\_\_\_\_\_\_\_\_\_ Colon, Invasive / Age @ Diagnosis \_\_\_\_\_\_\_\_\_\_ Other Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age @ Diagnosis \_\_\_\_\_\_\_\_ Other Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age @ Diagnosis \_\_\_\_\_\_\_\_ Other Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age @ Diagnosis \_\_\_\_\_\_\_\_ |  None (No Family History)Relationship \_\_\_\_\_\_\_\_\_\_ Site/Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ Age @ Diagnosis \_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_ Site/Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ Age @ Diagnosis \_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_ Site/Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ Age @ Diagnosis \_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_ Site/Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ Age @ Diagnosis \_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_ Site/Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ Age @ Diagnosis \_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_ Site/Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ Age @ Diagnosis \_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_ Site/Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ Age @ Diagnosis \_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_ Site/Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ Age @ Diagnosis \_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_ Site/Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ Age @ Diagnosis \_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_ Site/Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ Age @ Diagnosis \_\_\_\_\_\_ |

\*\*Please specify which (if any) relatives have had KRAS-variant testing and their results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Care Provider’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Mira DX 300 George Street Suite 515, New Haven, CT 06511 Phone: (203)789-9000 Fax: (203)789-9100*