mira DX

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:** _____

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