



# TheraGuide 5-FU<sup>TM</sup>

Comprehensive Analysis of the DPYD and TYMS genes  
for 5-FU/Capecitabine Toxicity

MYRIAD GENETIC LABORATORIES, INC.  
A CLIA Certified Laboratory

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## Test Request Form INCOMPLETE FORMS MAY DELAY TESTING

SPECIMEN COLLECTION DATE (REQUIRED)
07-02-07

**AFFIX LABEL TO SPECIMEN CONTAINER**  
Please label blood tube(s) with patient name/ID and birth date

ORDERING PHYSICIAN				AUTHORIZED HEALTH CARE PROVIDER TO RECEIVE RESULTS							
LAST NAME <b>Quincy</b>		FIRST NAME <b>John</b>		INITIAL <b>A</b>		LAST NAME		FIRST NAME		INITIAL	
DEGREE / SPECIALTY <b>MD Oncology</b>		UPIN / NPI # <b>000000000</b>		OFFICE CONTACT NAME <b>Jane Doe</b>		DEGREE		SPECIALTY		OFFICE CONTACT NAME	
INSTITUTION <b>Health Center</b>				OFFICE CONTACT PHONE <b>000-000-0000</b>		INSTITUTION				OFFICE CONTACT PHONE	
ADDRESS - 1 <b>123 Health Center Drive</b>				OFFICE CONTACT FAX <b>000-000-0000</b>		ADDRESS - 1				OFFICE CONTACT FAX	
ADDRESS - 2				OFFICE CONTACT E-MAIL		ADDRESS - 2				OFFICE CONTACT E-MAIL	
CITY <b>Lake City</b>			BAR CODE NUMBER			CITY			BAR CODE NUMBER		
STATE <b>ST</b>	ZIP <b>12345</b>	COUNTRY <b>USA</b>		STATE	ZIP	COUNTRY					

PATIENT INFORMATION													
PATIENT LAST NAME <b>Sample</b>			PATIENT FIRST NAME <b>Ima</b>			INITIAL <b>T</b>		PATIENT ID#		SSN <b>000-00-0000</b>		<input checked="" type="checkbox"/> FEMALE	BIRTH DATE <b>08/08/1945</b>
STREET ADDRESS <b>345 Lake Street</b>					CITY <b>Lake City</b>		STATE <b>ST</b>	ZIP <b>12345</b>		DAYTIME PHONE NUMBER <b>000-000-0000</b>			

ANCESTRY & CLINICAL HISTORY									
<input type="checkbox"/> WESTERN / NORTHERN EUROPE	<input checked="" type="checkbox"/> CENTRAL / EASTERN EUROPE		<input type="checkbox"/> AFRICA		<input type="checkbox"/> NEAREAST / MIDEAST				
<input type="checkbox"/> ASHKENAZI	<input type="checkbox"/> LATIN AMERICAN / CARIBBEAN			<input type="checkbox"/> ASIA		<input type="checkbox"/> NATIVE AMERICAN		<input type="checkbox"/> OTHER _____	
WHAT DRUGS HAS THIS PATIENT RECEIVED?									
<input checked="" type="checkbox"/> NONE	<input type="checkbox"/> 5-FU + LEUCOVORIN	<input type="checkbox"/> CAPECITABINE	<input type="checkbox"/> FOLFOX	<input type="checkbox"/> FOLFIRI	<input type="checkbox"/> CAF	<input type="checkbox"/> CMF	<input type="checkbox"/> CF	Other: _____	
IF TREATED ALREADY WITH 5-FU OR CAPECITABINE, WHAT GRADE 3 OR 4 TOXICITY DID THIS PATIENT EXPERIENCE? <input type="checkbox"/> NONE									
GRADE 3 or 4: <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Stomatitis	<input type="checkbox"/> Hand & Foot	<input type="checkbox"/> Hematopoietic	Other: _____					
WHAT KIND OF CANCER DOES THIS PATIENT HAVE?									
<input type="checkbox"/> BREAST: Age at Dx _____		<input type="checkbox"/> COLORECTAL: Age at Dx _____		<input type="checkbox"/> HEAD & NECK: Age at Dx _____		<input type="checkbox"/> STOMACH: Age at Dx _____			
<input type="checkbox"/> CERVICAL: Age at Dx _____		<input checked="" type="checkbox"/> PANCREATIC: Age at Dx <b>60</b>		<input type="checkbox"/> OTHER CANCER: _____ Age at Dx _____					
ICD-9 CODE(s)/ Dx <b>153.9</b>									

HEALTHCARE PROVIDER'S SIGNATURE									
I hereby authorize testing and confirm that informed consent has been obtained, if required under state law.									
					<u>John Quincy</u>			<u>07/04/2007</u>	
					Health Care Provider's Signature			Date	
(NOTE: Test requests without a signature will not be processed)									

BILLING / PAYMENT INFORMATION (CHECK ONE OF THE FOLLOWING OPTIONS. TESTING WILL BE DELAYED WITHOUT COMPLETE PAYMENT INFORMATION)									
INSURANCE BILLING - (Insurance billing requires patient signature and readable (enlarged) copy of both sides of insurance card(s). If two cards are submitted, indicate which is primary.)									
I acknowledge I've selected insurance billing option, and hereby authorize Myriad Genetic Laboratories, Inc. ("MGL") to furnish my designated insurance carrier, health plan, or third-party administrator, (collectively, "Plan"), the information on this form and other information provided by my healthcare provider if necessary for reimbursement. I authorize my Plan to disclose to MGL information concerning my Plan, including coverage benefits and limitations, and payments made for services. I understand that I am responsible for any amount not paid by my Plan for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.									
Patient/Responsible Party Signature: <u>Ima Sample</u>							Date: <u>07/04/2007</u>		<b>Reminder: Insurance card copies must be included</b>

PATIENT PAYMENT (Please call Customer Service for questions regarding test prices.)									
I have provided full payment for the test in the amount of \$ _____ as indicated below.									
<input type="checkbox"/> Self-pay: Personal Check# _____, Cashier's Check or Money Order is enclosed, payable to: Myriad Genetic Laboratories, Inc.									
Credit card: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AMEX Card # _____ Exp. Date: _____									
Cardholder Name (please print): _____					Cardholder Signature: _____				
<input type="checkbox"/> OTHER BILLING									
<input type="checkbox"/> Bill our institutional account # _____ (to establish an account, submit billing information with this form) <i>or</i> Bill established research project code # _____									
<input type="checkbox"/> Myriad has authorized research testing for this patient. "MGA" number assigned: _____ Relation to original patient: _____									

LAB USE ONLY:									
Sample Type:		Rcvd By:		Date:		Funds Received:		Draw Date from Specimen Tube:	
5FU TRF-06/07						Check Cash		No Date on Tube	