# Tamoxifen Pharmacogenetics Test Requisition
## Mount Sinai Genetic Testing Laboratory - Mount Sinai Medical Center

**PATIENT INFORMATION:**

Patient's Name: Last _____ First _____ Date of Birth: ____/____/____

Gender: ☐ Male ☐ Female Ethnicity: ☐ Caucasian ☐ African-American ☐ Asian ☐ Native American ☐ Hispanic ☐ Other: _____

Patient's Address: Street: _____ City: _____ State: _____ Zip: _____

Telephone (Home): _____ (Cell): _____ (Work): _____

**PHYSICIAN INFORMATION:**

Name: _____ Institution: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Fax Number: _____ E-mail Address: _____

INDICATIONS FOR TEST: _____ ICD9 Dx Code: _____

Physician's Signature: _____ Genetic Counselor: _____

**BILLING/INSURANCE INFORMATION:**

Name of Policyholder: Last _____ First _____ Policyholder DOB: ____/____/____

Insurance Carrier: _____ Ins ID: _____ Group: _____

Billing Address: _____

Other Health Coverage? (Identify): _____

**LABORATORY TEST(S) ORDERED:**

Specimen Type: ☐ Green Top (Sodium Heparin) ☐ Purple Top (EDTA)

Date/Time Specimen Drawn: ____/____/____

Date Specimen Sent: ____/____/____

Tamoxifen Pharmacogenetics Tests:

☐ Tamoxifen Metabolites

☐ Genotype ☐ CYP2D6 ☐ Others: _____

*Requirements for Tamoxifen Metabolites Assay:*
*Patients Preparedness: Test is validated for steady-state metabolites concentrations. Patients should be on standard dose of tamoxifen (20 mg/day) for at least 3 months.*
*Specimen requirement and handling: 1 tube of 10 ml blood in sodium heparin (green tops) tube protected from light before patient takes their daily dose of tamoxifen. Local clients, contact 212-241-7518 for specimen pick up to deliver to Mount Sinai Genetic Testing Laboratory on the same day. If specimen cannot be delivered to the lab on the same day, separate the plasma immediately, freeze and ship frozen plasma on dry ice via overnight courier.*

**CLINICAL INFORMATION:**

Tumor Characteristics: _____

Treatment History:

Is patient currently on or planning tamoxifen treatment? ☐ PLANNED ☐ ON TREATMENT How long: _____

☐ Tamoxifen Dose _____

Is patient taking other medications? ☐ NO ☐ YES

If YES, please specify:

_____

_____

_____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to Mt. Sinai Genetic Testing Lab and I understand that I am financially responsible for uncovered services. I also authorize the release of any information required to process this claim.
Signed: _____

| | |
|---|---|
| TOTAL CHARGES: | $ |
| AMOUNT PAID: | $ |
| BALANCE DUE: | $ |

Telephone 212-241-7518
Fax 212-241-0139
Tax ID# 13-6171197

Billing 212-241-8717
CLIA# 33D0653419

*Make Check Payable to:*
Mt. Sinai Genetic Testing Lab
One Gustave L. Levy Place, Box 1497
New York, NY 10029-6574

# Mount Sinai Genetic Testing Laboratory

*Department of Genetics and Genomic Sciences, Mount Sinai School of Medicine*

MOUNT SINAI SCHOOL OF MEDICINE

## Genetic Testing Laboratory Informed Consent
## Tamoxifen Pharmacogenetic Testing

****Informed consent is mandatory for tamoxifen pharmacogenetic testing****

I, _____, hereby request DNA-based testing for variations in a gene
*Print Full Name*

that may affect the outcome of tamoxifen treatment. I have received verbal and/or written information from my physician or from a genetic counselor that described, in words that I understood, the nature of the genetic testing that I am about to undergo.

I understand that I am being tested for variations in one gene. These variations may affect the way I metabolize and respond to tamoxifen. I will be classified as a standard or a better or poorer responder to tamoxifen.

This testing may allow my doctor to more effectively define a tamoxifen regimen for me. However, I understand that this testing does not take into account other genetic or non-genetic factors that may influence proper treatment and my doctor should interpret the results relative to my clinical situation.

The nature of DNA testing has been explained to me and the accuracy of the test and its limitations have been detailed. I understand that while results obtained from DNA testing are usually highly accurate, infrequent errors may occur. The likelihood of this occurring has been estimated to be less than 1%.

The results of the testing will be released only to the ordering physician as required by New York State law. The results will not be released to anyone else without my written authorization. The results of my test will be explained to me by my physician who will have the opportunity to discuss my results with a Biochemical/Molecular Geneticist or Genetic Counselor.

The sample (blood and DNA) will be kept for approximately 60 days after the testing is complete (as is acceptable in NYS CLIA-approved diagnostic laboratories), and then will be destroyed. This stored sample will be identifiable in that it will be labeled with my name and date of blood draw.

I have had the opportunity to have all of my questions answered. I understand that this consent is being obtained in order to protect my right to have all of my questions answered before testing. I also understand that the results of this testing will become part of my medical record and may only be disclosed to individuals who have legal access to this record or to individuals who I designate to receive this information.

_____ _____
*Signature of Person Being Tested* *Date*

_____ _____
*Signature of Witness* *Date*