GENOMIC TESTING COOPERATIVE®

Genomic Testing Cooperative, LCA
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Reducing Cancer Health Disparity Program

Patient Nomination Form

GTC is dedicated to reducing the gap in cancer health disparity. This program provides patients with the opportunity for comprehensive genomic profiling, regardless of their ethnic, social, and financial status.

Our practice abides by the contractual and legal obligations of health benefit plans to collect charges, co-pays, co-insurance, and deductible amounts owed by patients. Recognizing that ethnic and racial minorities, impoverished people, sexual and gender minorities (LGBT+) are typically affected more negatively with cancer and often are not covered by insurance, we have established this program of physician nominations to request complete cancer profiling (DNA+RNA). To do this, we must ask for the ordering Physician to complete this form and return to GTC. All information will be held confidential according to our HIPAA-compliant privacy policy.

Patient Information

First Name		Last Name		Date of Birth	
Address		City		State	
Zip Code		Phone			

Patient Race (check one)

☐ American Indian ☐ African American ☐ Alaskan Native ☐ Native Hawaiian
☐ Asian ☐ Caucasian ☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Mixed: _____ ☐ Other: _____

Patient Sex: ☐ Male ☐ Female

Sexual Orientation
☐ Heterosexual/Straight ☐ Gay ☐ Lesbian
☐ Bisexual ☐ Not listed above (please specify) _____

Family Type:

☐ Single ☐ Single parent with children ☐ Married couple or partners
☐ Two parent family with children ☐ Other: _____

Marital Status:
☐ Married ☐ Cohabitating Partner ☐ Divorced or separated
☐ Widowed ☐ Never married

Income (per person/household): ☐ < $ 40,000 ☐ < $ 30,000 ☐ < $20,000

Disability Status: ☐ without disability ☐ with disability: _____
Country of Birth: ☐ US ☐ Outside US
Drug Dependency: ☐ No ☐ Yes
If Yes ☐ Current ☐ History

As a Representative of the patient, or an Ordering Physician completing this application on the patient's behalf, I hereby confirm that the above information is true and accurate.
My signature certifies that I have explained to the patient the nature and purpose of this nomination and that the patient has consented to my completing the nomination on his/her behalf.

Physician name:		Signature	
Facility			
Address of Facility		Date	
Phone Number	E-mail		

Please return this form to:
Genomic Testing Cooperative - Attn: Billing Department - 175 Technology Dr, Suite 100, Irvine, CA 92618
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