

# BRAF Genetic Test

Patient Information	
Patient Name:	
Date of Birth:	
Gender:	
Phone Number:	
Known Allergies:	
Medical Conditions:	
Current Medications:	

Type of Test: BRAF Genetic Test	
Date of Test:	
Ordering Physician:	
Reason for Testing:	

BRAF Gene Mutation Analysis	
DNA Sample Source:	
BRAF Gene Mutation Status	
Type of Mutation (if detected):	

Results	
Follow up:	

Interpretation of Results:	
BRAF Gene Mutation Status:	
Clinical Implications:	
Treatment Recommendations:	

Genetic Counselor Signature:

Healthcare Provider Signature:

Patient Signature:

Date of the Report: