PREMIER GENOMICS

ACOG/ACMG TEST REQUISITION

PATIENT INFORMATION

Patient Name (Last, First)	Date of Birth	Pregnant? ☐ Yes ☐ No
Street Address	City, State, Zip	Gender ☐ Female ☐ Male

BACKGROUND AND FAMILY HISTORY

CHECK ALL THAT APPLY	YOU	PARTNER
Adopted	☐	☐
African American/Black	☐	☐
American Indian	☐	☐
Asian/Pacific Islander	☐	☐
Cajun/French Canadian	☐	☐
Caucasian	☐	☐
Hispanic	☐	☐
Mediterranean	☐	☐
Unsure	☐	☐
Other (list):		

PERSONAL AND FAMILY GENETIC DISORDERS

CHECK ALL THAT APPLY	YOU	PARTNER	FAMILY
Sickle Cell/Thalassemia	☐	☐	☐
Autism/Autism Spectrum Disorder	☐	☐	☐
Intellectual Disability	☐	☐	☐
Infertility	☐	☐	☐
Other genetic condition; list what condition: (check all that apply)			
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Partner is confirmed carrier ☐ Yes ☐ No If so, what is he/she a carrier of (list):

Patient acknowledgment for direct insurance/3rd party billing: I hereby authorize my insurance benefits to be paid directly to the lab rendering the test and authorize them to release medical information concerning my testing to my insurer. If applicable, I authorize this lab to be my Designated Representative for purposes of appealing any denial of benefits. I understand that I am financially responsible for any amounts not covered by my insurer for this test order. I also fully understand that I am legally responsible for sending the lab any money received from my health insurance company for performance of this test. Further, I authorize the provider to release any pertinent medical records.

Patient or Legally Authorized Representative | Date | Patient Email

ORDERING PHYSICIAN AND/OR OTHER LICENSED MEDICAL PROFESSIONAL

NPI #	Name (Last, First)	Facility Name
Street Address	City, State, Zip	
Phone	Fax	Email

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR TESTING

By ordering testing, the undersigned person represents that he/she is a licensed medical professional authorized to order genetic testing OR is a representative of a licensed medical professional authorized to order testing: acknowledges the patient has been supplied information regarding genetic testing and the patient has given consent for testing to be performed. I request clinical interpretation of these results and confirm that this testing is medically necessary for the diagnosis or detection of a disease and that these will be used in the medical management and treatment decisions for this patient. Further, the recipient's information is true and correct to the best of my knowledge.

Medical Professional Signature | Date

CARRIER SCREENING TEST SELECTION

☐ ACOG/ACMG Comprehensive Carrier Screen Panel
☐ Cystic Fibrosis ☐ SMA ☐ Fragile X ☐ Pan-Ethnic Diseases

Collection date

DIAGNOSIS/ICD-10: PLEASE ENSURE THAT ALL CODES CIRCLED ARE REPRESENTATIVE OF THE PATIENT BEING SEEN AND THEIR HEALTH CONSIDERATIONS.

Description	ICD-10
GENERAL	
Supervision of Other Normal Pregnancy	Z34.80
Testing Female for Genetic Disease Carrier Status	Z31.430
Other Genetic Testing of Female	Z31.438
Testing Male for Genetic Disease Carrier Status	Z31.440
Screening for Cystic Fibrosis	Z13.228

Description	ICD-10
SPECIFIC	
Family History of Intellectual Disabilities	Z81.0
Family History of Genetic Disease Carrier	Z84.81
Ovarian Dysfunction, Unspecified	E28.9
Unspecified History of Intellectual Disability	F79
Other Genetic Carrier Status	Z14.8
Fragile X Syndrome	Q99.2