

PATIENT INFORMATION

Patient Name (Last, First)	Date of Birth	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address	City, State, Zip	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male

BACKGROUND AND FAMILY HISTORY
PERSONAL AND FAMILY GENETIC DISORDERS

CHECK ALL THAT APPLY	YOU	PARTNER	CHECK ALL THAT APPLY	YOU	PARTNER	FAMILY
Adopted	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell/Thalassemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
African American/Black	<input type="checkbox"/>	<input type="checkbox"/>	Autism/Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
American Indian	<input type="checkbox"/>	<input type="checkbox"/>	Intellectual Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asian/Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cajun/French Canadian	<input type="checkbox"/>	<input type="checkbox"/>	Other genetic condition; list what condition: (check all that apply)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caucasian	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hispanic	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mediterranean	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unsure	<input type="checkbox"/>	<input type="checkbox"/>	Partner is confirmed carrier <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what is he/she a carrier of (list):			
Other (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
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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
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CARRIER SCREENING TEST SELECTION

<input type="checkbox"/> ACOG/ACMG ECS Comprehensive Carrier Screen Panel <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> SMA <input type="checkbox"/> Fragile X <input type="checkbox"/> Pan-Ethnic Diseases	Collection date
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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