

Genetic Testing: Noninvasive Prenatal Screening and Carrier Screening Requisition Form



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PATIENT INFORMATION			
First Name		Last Name	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY)	Last 4 Digits of SS #	
Gender (optional): _____			
Address			
City	State	Zip Code	
Email			
Primary Phone		Cell Phone	
Patient Status - one must be checked: <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Hospital Inpatient - Date of Discharge: _____ <input type="checkbox"/> Not a Hospital Patient			

BILLING INFORMATION
Bill to: <input type="checkbox"/> Client <input type="checkbox"/> Patient (Self-Pay) <input type="checkbox"/> Patient Insurance

PATIENT INSURANCE INFORMATION	
Please include copy of insurance card (front/back)	
MEMBER NAME	
DATE OF BIRTH (MM/DD/YYYY)	RELATIONSHIP TO PATIENT
MEMBER POLICY NUMBER	MEMBER GROUP NUMBER
INSURANCE COMPANY NAME	INSURANCE COMPANY PHONE
INSURANCE COMPANY ADDRESS	
CITY	STATE ZIP CODE
PRIOR AUTHORIZATION # (IF APPLICABLE)	FAP REFERENCE # (IF APPLICABLE)

REQUIRED PRIOR AUTHORIZATION INFORMATION
<p>Please attach/include:</p> <ul style="list-style-type: none"> • Copy of Insurance Card • Relevant Clinical Notes, Test Reports (i.e. ultrasound findings, family genetic pedigree) • Sample • Completed Requisition Form

PATIENT AUTHORIZATION/ASSIGNMENT	
<input type="checkbox"/>	I AUTHORIZE HNL Lab Medicine to retain and use my de-identified specimen and test data (where all information that could link me to the specimen or data has been removed) for research and/or help develop new products or services, in compliance with applicable laws.
<input type="checkbox"/>	I DO NOT AUTHORIZE HNL Lab Medicine to retain and use my de-identified specimen and test data as described above. If a signature is present but box is not checked, consent is implied. All leftover specimens from New York State will be destroyed within 60 days
<input type="checkbox"/>	I AUTHORIZE HNL Lab Medicine to contact me via email, cellular or home phone, text message, or computer assisted technology for billing matters.
<input type="checkbox"/>	I AUTHORIZE HNL Lab Medicine to obtain and release relevant medical and other information to Medicare, Medicaid, Medicare Supplemental and any other insurance providers for laboratory services provided to me.
PATIENT/GUARDIAN SIGNATURE:	DATE (MM/DD/YYYY):
<div style="border: 1px solid black; padding: 5px; display: inline-block;">Required</div>	

PATIENT SCREENING INFORMATION		
ORDER DATE (MM/DD/YYYY)	COLLECTION DATE (MM/DD/YYYY)	
IS THE PATIENT CURRENTLY PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No		
NAME OF LEGAL GUARDIAN IF PATIENT IS A MINOR		
PATIENT ETHNICITY <input type="checkbox"/> Asian <input type="checkbox"/> French Canadian/Cajun <input type="checkbox"/> Jewish, Non-Ashkenazi <input type="checkbox"/> Other <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Middle Eastern <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Jewish, Ashkenazi <input type="checkbox"/> Native American		
DOES THE PATIENT HAVE A KNOWN FAMILY HISTORY OF GENETIC DISEASE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF YES TO ABOVE, INCLUDE RELEVANT FAMILY HISTORY		
THE FOLLOWING FIELDS ARE REQUIRED FOR NIPS ORDERS:		
IS THERE AN INCREASED RISK OF CHROMOSOMAL ABNORMALITIES? (EX. POSITIVE SERUM SCREEN, ULTRASOUND FINDINGS, PRIOR PREGNANCY WITH TRISOMY, ETC.)		
SAMPLE TYPE <input type="checkbox"/> Singleton <input type="checkbox"/> Twin	ESTIMATED DATE OF DELIVERY (EDD)	MATERNAL WEIGHT

REPORTING INFORMATION		
ORDERING HEALTH CARE PROFESSIONAL		
NAME	NPI NUMBER	
TITLE / ROLE		
GENETIC COUNSELOR		
INSTITUTION		
TELEPHONE NUMBER	FAX NUMBER	
E-MAIL		
STREET NUMBER	STREET NAME	SUITE NUMBER
CITY	STATE	ZIP
COPY RESULTS TO NAME		COPY RESULTS TO FAX

REPORTING INFORMATION

ADDITIONAL REPORTS

REFERRING LAB		REFERRING LAB ID#
CONTACT PERSON		
TELEPHONE NUMBER	FAX NUMBER	
E-MAIL		
STREET NUMBER	STREET NAME	SUITE NUMBER
CITY	STATE	ZIP

ACKNOWLEDGEMENT: I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given consent as required under applicable laws and regulations for the test(s) to be performed. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purposes for this patient. I confirm that the person listed as the Ordering Clinician is authorized by law to order the tests(s) requested herein.

PROVIDER SIGNATURE

DATE (MM/DD/YYYY)

Required

INDICATION FOR TESTING

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ICD-10 CODE(S): (REQUIRED)

TEST CODES:

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HOW WILL THE RESULT OF THIS TEST INFLUENCE THE MANAGEMENT OF PREGNANCY, DIAGNOSIS, OR THE PATIENT'S TREATMENT PLAN?

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ADDITIONAL INFORMATION

PLEASE PROVIDE ANY OTHER RELEVANT INFORMATION (IVF PREGNANCY, EGG DONOR, RECENT MATERNAL BLOOD TRANSFUSION, ETC.)

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NONINVASIVE PRENATAL SCREENING (NIPS)

TEST CODE	TEST OPTION
<input type="checkbox"/> NIPT	Trisomy 21, 18, and 13 screening
	<input type="checkbox"/> Report fetal sex and X and Y aneuploidy <input type="checkbox"/> DO NOT report fetal sex and X and Y aneuploidy
	If no fetal sex reporting option is selected, the test will automatically default to NOT report fetal sex and X and Y aneuploidy
	NOTE: FOR NIPS TESTING, PATIENT SHOULD NOT BE DRAWN BEFORE 10 WEEKS GESTATIONAL AGE

CARRIER SCREENING TESTS

PANEL TESTING

TEST CODE	DISORDER / PANEL	GENES
<input type="checkbox"/> 6000	Common Carrier Screening Panel	ASPA, BCKDHA, BLM, CFTR, DMD, ELP1, FANCC, FMR1, GBA, HBA1, HBA2, HBB, HEXA, MCOLN1, PAH, SMN1, SMN2, SMPD1
<input type="checkbox"/> 6001	Extended Carrier Screening Panel	ACADM, ARSA, ARSB, ASPA, ASS1, BCKDHA, BCKDHB, BLM, BTD, CFTR, DHCR7, DMD, ELP1, FANCC, FMR1, G6PC, GAA, GALT, GALE, GALK1, GALT, GAMT, GATM, GBA, GLA, HBA1, HBA2, HBB, HEXA, IDS, IDUA, IVD, MCOLN1, MMACHC, OTC, PAH, PHKA2, PHKG2, PKHD1, PYGL, SLC37A4, SLC6A8, SMN1, SMN2, SMPD1, SUMF1

RELATED CARRIER SCREENING TESTS

<input type="checkbox"/> 6002	Cystic fibrosis	CFTR
<input type="checkbox"/> 6003	Duchenne muscular dystrophy, Becker muscular dystrophy, Dilated Cardiomyopathy 3B	DMD
<input type="checkbox"/> 6004	Fragile X syndrome, Fragile X tremor/ataxia syndrome, Premature ovarian failure 1	FMR1
<input type="checkbox"/> 6005	Alpha Thalassemia	HBA1, HBA2
<input type="checkbox"/> 6006	Sickle Cell Anemia, Beta Thalassemia	HBB
<input type="checkbox"/> 6007	Phenylketonuria	PAH
<input type="checkbox"/> 6008	Spinal muscular atrophy	SMN1, SMN2

Any gene in the Carrier Screening panels can be run as a single disorder test

Please fill out the above information and sign. This form should be submitted with the specimen to 794 Roble Road, Allentown, PA, 18109.