

PATIENT INFORMATION

First name	MI	Last name	Date of birth (MM/DD/YYYY)		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sex	MRN (medical record number)	Ancestry			
<input type="radio"/> M <input type="radio"/> F	<input type="text"/>	<input type="radio"/> Asian <input type="radio"/> Black/African American <input type="radio"/> White/Caucasian <input type="radio"/> Ashkenazi Jewish <input type="radio"/> Hispanic <input type="radio"/> Native American <input type="radio"/> Pacific Islander <input type="radio"/> French Canadian <input type="radio"/> Sephardic Jewish <input type="radio"/> Mediterranean <input type="radio"/> Other: _____			
Email address (for report access after release by medical professional)			Phone		
<input type="text"/>			<input type="text"/>		
Address					
<input type="text"/>					
City	State	ZIP code	Country		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		

ORGANIZATION INFORMATION

Organization name and address					
Organization name				Phone	
Address				Fax	
City	State	ZIP code	Country		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Primary clinical contact					
Name				NPI	
Email address (for report access)				Phone	
Ordering physician					
<input type="radio"/> Same as primary clinical contact					
Name				NPI	
Email address (for report access)				Phone	
Additional clinical or laboratory contacts (optional)					
Name	Email address (for report access)	Name	Email address (for report access)		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Name	Email address (for report access)	Name	Email address (for report access)		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		

<input type="radio"/> INSURANCE BILLING (Please attach a copy of the patient's card.)	
We do not accept insurance for certain tests or patients outside the US. Before completing this section, confirm your test is eligible at www.invitae.com/billing.	
Primary insurance company name	Primary member ID#
<input type="text"/>	<input type="text"/>
Secondary insurance company name	Secondary member ID#
<input type="text"/>	<input type="text"/>
<input type="radio"/> Patient has Medicare and was treated as a hospital inpatient (>24 hour stay) in the last 14 days.	Prior-authorization #
<input type="text"/>	<input type="text"/>
Letter of Medical Necessity (LMN)	
<input type="radio"/> I have attached an LMN and/or other documents for insurance billing purposes.	
<input type="radio"/> I agree to allow Invitae to transfer the information from this requisition to an LMN and/or other documentation using the ordering physician's name as the signature for insurance billing.	

<input type="radio"/> INSTITUTIONAL BILLING
Invitae will send an invoice to the organization address above. Please contact Invitae if this order should be billed to a different location.

<input type="radio"/> PATIENT PAY BILLING
Invitae will send an electronic invoice to the patient email listed above

<input type="radio"/> OTHER BILLING
Invitae partner code:
<input type="text"/>

SPECIMEN INFORMATION

 Label each tube with the patient's full name, date of birth, and specimen collection date. A requisition form MUST accompany each specimen. www.invitae.com/specimen-requirements
Collection date (MM/DD/YYYY)
 / /

If not provided, date will be 1 day prior to our receipt of specimen. For DNA, provide date retrieved from archive.

Specimen type
 Blood Saliva DNA source: _____

DNA must be extracted in a CLIA or other suitably certified laboratory. We are unable to accept blood/saliva from patients with allogeneic bone marrow transplants or blood transfusion <2 weeks prior to specimen collection.

Special cases
 Resubmission

Specimen ID (IB# found on tube) - optional:

OPTIONAL: PERSONAL OR FAMILY HEALTH HISTORY**TEST INFORMATION**

 Invitae continually updates its panels based on the most recent evidence. Please note that if an order is placed using an older version of these forms, Invitae reserves the right to upgrade any ordered panel(s) to the current version(s). To avoid confusion, please consider placing your order using our online test catalog. To view a full gene list for the panels, please visit our website www.invitae.com and indicate your selections below.

Test code	Test name	# gene(s)
<input type="radio"/> 11001	Invitae Genetic Health Screen	147
<input type="radio"/> 12001	Invitae Cancer Screen	61
<input type="radio"/> 13001	Invitae Cardio Screen	77

 To request a complimentary specimen collection kit visit www.invitae.com/request-a-kit
SHIPPING INSTRUCTIONS

Please ship specimen overnight in insulated containers:

**Attn: Invitae Client Services
1400 16th Street, San Francisco, CA 94103, USA**

By signing this form, the medical professional acknowledges that the individual/family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo genetic testing, substantially as set forth in Invitae's Informed Consent for Genetic Testing (for patients in the US: www.invitae.com/proactive-consent; for patients outside the US: www.invitae.com/proactive-consent-international), has been informed that Invitae may notify them of clinical updates related to genetic test results (in consultation with the ordering medical professional as indicated), and for orders originating outside the US, has been informed that the Patient's personal information and specimen will be transferred to and processed in the US. The Patient has further been informed and authorizes Invitae Corporation ("Invitae") and its designees to release information concerning testing to their insurer, if applicable, in order to process and/or appeal claims on behalf of the Patient. If a letter of medical necessity (LMN) has not been provided, the medical professional agrees to allow Invitae to transfer the information from this requisition to a LMN and/or other documentation using the medical professional's name as the signature for insurance billing. For amounts received directly, the Patient has agreed to remit payment to Invitae for testing services rendered. I acknowledge that I offered pre-test genetic counseling to the Patient, if required by their insurer. In addition to the above, I attest that I am the ordering physician, or I am authorized by the ordering physician to order this test, or I am authorized under applicable law to order this test.

Medical professional signature

Date

PATIENT CONSENT FOR PROACTIVE TESTING

I, _____, request and permit Invitae to analyze the genes indicated on the test requisition form in my sample.

I UNDERSTAND THAT:

1. More information about the Invitae Proactive tests is available from my healthcare provider.
2. The results of this DNA test could be:
 - a. Positive, and may:
 - i. alert me to a predisposition or an increased risk for developing a genetic disease in the future.
 - ii. have implications for risk of disease in other family members.
 - b. Negative, and may:
 - i. indicate disease risks close to that of the general population but do not eliminate the risk for developing a genetic disease in the future.
3. Molecular genetic tests may or may not provide actionable information or have an implication for my medical management.
4. Some types of DNA changes that could cause a specific genetic disorder may not be detected by this test. As with most molecular genetic tests, Invitae's test has technical limitations that may prevent detection of certain changes due to poor DNA quality, inherent DNA sequence properties, or other types of limitations.
5. There may be possible sources of error including, but not limited to, trace contamination, rare technical errors in the laboratory, rare DNA variants that compromise data analysis, inconsistent scientific classification systems, and inaccurate reporting of family relationships or clinical diagnosis information.
6. Invitae will only interpret the parts of the DNA sequence of the genes indicated on the requisition form by my physician.
7. Invitae's clinical reports are released only to me and the certified healthcare professional(s) listed on the test requisition form. Clinical reports are confidential and will only be released to other medical professionals with my explicit written consent.
8. It is my responsibility to consider the possible impact of my test results as they relate to insurance rates, obtaining disability or life insurance, implications for family members, and employment. The Genetic Information Nondiscrimination Act (GINA), a federal law, provides some protections against genetic discrimination. For information on GINA visit <http://www.genome.gov/10002328>.
9. The Invitae Proactive tests are screening genetic tests. This means that DNA variants that provide medically relevant information for me or have implications for my medical management will be reported by this test. I may also receive a result that indicates that I carry a genetic change that does not increase my own risk of developing a specific medical condition, but that may be passed within my family (also known as carrier status).
10. I will be offered genetic counseling with a geneticist, genetic counselor or other qualified healthcare provider who can answer questions, provide information and advise about alternatives before and after having this test. Further testing or additional physician consults may be warranted.
11. My data and personal information will be stored and protected in strict confidence complying with regulatory requirements (e.g. HIPAA and equivalent protections), and acknowledge that I have read and understand [Invitae's Privacy Policy](#) and [Notice of Privacy Practices](#). My individually identifiable health information (i.e., "Protected Health Information" under HIPAA) will NOT be used in FOR PROFIT research without my additional, explicit consent.
12. Because the understanding of genetic information will improve over time, Invitae may notify me of clinical updates related to my genetic profile (in consultation with my primary clinician as indicated).
13. I have the right to receive a copy of this consent form.

BY SIGNING BELOW, I ATTEST TO THE FOLLOWING:

1. I have been informed of the likelihood of finding a change in the genes for which I am being tested and have received test-specific clinical information.
2. I have read and understand the information provided on this form and have had an opportunity to have any questions answered by my healthcare provider.

Patient signature	Date
Print name of patient	Email address

Check here to opt out of being contacted for research studies (doing so will not affect the care provided to you by Invitae).

HEALTHCARE PROVIDER STATEMENT: By signing below, I attest that I am the referring physician or authorized healthcare professional. I have explained the purpose of test described above. The patient has had the opportunity to ask questions regarding this test and/or seek genetic counseling. The patient has voluntarily decided to have this test performed by Invitae.

Healthcare provider signature	Date
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