INVITAE

ORDER ONLINE at www.invitae.com/signin.

**SHIPPING INSTRUCTIONS**
Please ship specimen overnight in insulated containers:
**Attn: Invitae Client Services, 1400 16th Street**
**San Francisco, CA 94103, USA**

**ORDER ID**
For Invitae internal use only

# Requisition Form
FAMILY VARIANT TESTING/VUS RESOLUTION **TRF920-3**

## PATIENT INFORMATION

First name | MI | Last name

Date of birth (MM/DD/YYYY) | Sex ◯ M ◯ F | MRN (medical record number)

Ancestry ◯ Asian ◯ Black/African American ◯ White/Caucasian ◯ Ashkenazi Jewish ◯ Hispanic ◯ Native American ◯ Pacific Islander ◯ Other:

Email address (for report access after release by medical professional)

Phone | Is this patient deceased? ◯ Yes ◯ No Deceased date:

Address | City

State | ZIP code | Country

## 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

Specimen type : ◯ Blood ◯ Saliva ◯ Assisted 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*
- *Blood transfusion <2 weeks prior to specimen collection*

**Collection date (MM/DD/YYYY)**

Special cases
◯ History of/current hematologic malignancy
◯ Resubmission

## REASON FOR TESTING

**ICD-10 codes**

**Previous results**

**Testing for a personal history of disease?** ◯ **Yes** ◯ **No** If yes, describe below.
Age at diagnosis: _____

## ORGANIZATION INFORMATION

**Organization name and address**

Organization name

Phone | Fax

Address | City

State | ZIP code | Country

**Primary clinical contact**

Name | Role/title

Phone | NPI

Email address (for report access)

**Ordering physician**

◯ **Same as primary clinical contact**

Name | NPI

Email address (for report access)

**Additional clinical or laboratory contact (optional)**

Name | Email address (for report access)

**Letter of Medical Necessity (LMN)**

◯ I have attached an LMN and/or other documentation for insurance billing purposes.

◯ 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.

**Family history?** ◯ **Yes** ◯ **No** If yes, describe in detail below or attach pedigree.

## ◯ INSURANCE BILLING (U.S. ONLY)

◯ **I have attached a copy of the patient's card**

Insurance company name | Member ID#

Patient relation to policy holder: ◯ Self ◯ Child ◯ Spouse ◯ Other

Policy holder name | Prior-authorization #

## ◯ PATIENT PAY BILLING

**Invitae will send an electronic invoice to the patient email listed above**

## ◯ INSTITUTIONAL BILLING

◯ **Send invoice to organization address above**

Billing contact name | Phone | Fax

Billing email address

Billing address | City

State | ZIP code | Country

## ◯ OTHER BILLING

Invitae partner code:

VUS case #:

## Invitae's family variant testing and VUS resolution program involves full analysis of the gene in which the original family member's variant was identified. For more information, visit www.invitae.com/family-testing.

***Please attach the original proband's clinical report or provide Invitae RQ#***

| | INVITAE PROBAND RQ# | RELATIONSHIP TO PROBAND | GENE(S)* | VARIANT(S) |
|---|---|---|---|---|
| ◯ **FAMILY VARIANT TESTING** | | | | |
| ◯ **VUS RESOLUTION** | | | | |

*If ordering a panel or additional gene(s) outside of the gene with a known familial variant, please use a standard requisition form

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, and 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). The Patient has further been informed and hereby authorizes Invitae Corporation ("Invitae") and its designees to release information concerning testing to their insurer in order to process and/or appeal claims on behalf of the Patient. For amounts received directly, the Patient agrees 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 state law to order this test.

**Medical professional signature** | **Date**

HEADQUARTERS & LABORATORY | 1400 16th Street, San Francisco, CA 94103 | www.invitae.com | IN THE US | clientservices@invitae.com | p: 800-436-3037 | f: 415-276-4164
OUTSIDE THE US | globalsupport@invitae.com or visit www.invitae.com/contact | 