

PATIENT INFORMATION		
First name	MI	Last name
Date of birth (MM/DD/YYYY)	Sex <input type="radio"/> M <input type="radio"/> F	MRN (medical record number)
Ancestry <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	Is this patient deceased? <input type="radio"/> Yes <input type="radio"/> No Deceased date:	
Address		City
State	ZIP code	Country

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

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. <a href="http://www.invitae.com/specimen-requirements">www.invitae.com/specimen-requirements</a>		
Specimen type : <input type="radio"/> Blood <input type="radio"/> Saliva <input type="radio"/> Assisted saliva <input type="radio"/> DNA - source: <i>DNA must be extracted in a CLIA or other suitably certified laboratory</i> <i>We are unable to accept blood/saliva from patients with:</i>		
<ul style="list-style-type: none"> <li>• Allogeneic bone marrow transplants</li> <li>• Blood transfusion &lt;2 weeks prior to specimen collection</li> </ul>		
Collection date (MM/DD/YYYY) <i>If not provided, date will be 1 day prior to our receipt of specimen. For DNA, provide date retrieved from archive.</i>		
Special cases : <input type="radio"/> History of/current hematologic malignancy <input type="radio"/> Resubmission		

REASON FOR TESTING	
ICD-10 codes	Previous results
Testing for a personal history of disease? <input type="radio"/> Yes <input type="radio"/> No If yes, describe below. Age at diagnosis: _____	

<b>Letter of Medical Necessity (LMN)</b>
<input type="radio"/> I have attached an LMN and/or other documentation 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.
<b>Family history?</b> <input type="radio"/> Yes <input type="radio"/> No If yes, describe in detail below or attach pedigree. If there is a known familial variant, indicate here.

INSURANCE BILLING (U.S. ONLY)	
<input type="radio"/> I have attached a copy of the patient's card	
Insurance company name	Member ID#
Patient relation to policy holder: <input type="radio"/> Self <input type="radio"/> Child <input type="radio"/> Spouse <input type="radio"/> Other	
Policy holder name	Prior-authorization #

INSTITUTIONAL BILLING		
<input type="radio"/> Send invoice to organization address above		
Billing contact name	Phone	Fax
Billing email address		
Billing address		City
State	ZIP code	Country

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

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](http://www.invitae.com/family-testing).

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

<input type="radio"/> FAMILY VARIANT TESTING	INVITAE PROBAND RQ#	RELATIONSHIP TO PROBAND	GENE(S)*	VARIANT(S)
<input type="radio"/> 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
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