Requisition Form – Parental/Familial Studies

INVITAE | CombiMatrix

Client Information

Referring Physician______________________ NPI__________________

Genetic Counselor/Clinical Contact ______________________________

Tel ______________________ Fax______________________

Email____

Authorized Signature ______________________________________

Patient Information

Last Name______________________ First Name ______________________

DOB ______________________ Gender______________________

Street Address______________________________________

City, State Zip ______________________________________

Tel ____

Email____

Medical Record Number ______________________________

Billing Information

Bill: ❑ My Account ❑ Insurance ❑ Medicare ❑ Medicaid ❑ Patient

Insurance Information ❑ See attached

Insured Information Name ______________________________

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other: ______________

Primary Insurance Company ______________ Authorization # ______________

Group # ______________________ Insured # ______________

Billing Address ______________________________________

Billing City, State, Zip ______________________________

Secondary Insurance Company ______________ Authorization # ______________

Group # ______________________ Insured # ______________

Billing Address ______________________________________

Billing City, State, Zip ______________________________

For Patient Bill cases, complete and submit "Self-Pay Testing Option" form. Testing will not be performed unless a completed form is received.

Patient Authorization/Assignment

I authorize CombiMatrix to obtain and release relevant medical and other information as needed to submit claims to Medicaid, Medicare, or Medicare Supplemental for laboratory services CombiMatrix provides to me. I assign insurance benefits to CombiMatrix and acknowledge that charges not covered by my insurance, including any applicable co-payments or deductibles, are my responsibility, and I agree to pay them.

____
Print Name of Patient or Guardian

____
Signature of Patient or Guardian Date (mm/dd/yyyy)

Specimen Information

Collection Date ______________________ # Tubes______________

Specimen ID #(s)______________________________________

Sample Type

❑ Whole blood - EDTA (purple top) ❑ Whole blood - NaHep (green top)

❑ Buccal swab (microarray only) ❑ Extracted DNA

❑ Other ______________________________

Indication for Testing

Parental/Familial Studies

If the patient or family member was previously tested at CombiMatrix, please complete this section.

❑ Evaluation of genetic disease carrier status for procreative management
❑ Female (Z31.430) ❑ Male (Z31.440)

❑ Family history of a chromosome abnormality (Z82.79)

❑ Other (description and ICD-10) ______________________________

Previously Tested Individual's Information

Name (Last, First, MI) ______________________ DOB ______________

CombiMatrix Accession# ______________ Year of Testing ______________

Relationship to Patient ______________________________

Recurrent Pregnancy Loss Studies (Karyotyping)

❑ Female recurrent pregnancy loss (N96)
❑ Male partner of patient with recurrent pregnancy loss (Z31.441)

Maternal Cell Contamination (MCC) Studies

If you are sending maternal blood for MCC analysis, please utilize the same ICD-10 code(s) as indicated on the original order.

❑ Indication for prenatal diagnostic testing (ICD-10) ______________________

Test Selections

Parental/Familial Studies

If a family member has had an abnormal result or a variant of unclear significance (VOUS) identified and parental/familial studies are recommended, the report will indicate which type of testing is to be performed. If you are uncertain regarding the recommended test type, please contact our Genetic Counseling Team at 949.753.0624 option 3.

❑ Chromosomal microarray analysis (purple top/EDTA or buccal swab)
❑ FISH (green top/NaHep)
❑ Karyotype (green top/NaHep)

Recurrent Pregnancy Loss

❑ Karyotype (green top/NaHep)

Maternal Cell Contamination (MCC) Studies (purple top/EDTA)

❑ MCC analysis following testing of a prenatal sample
❑ MCC analysis to accompany cultured prenatal sample for send-out testing

Special Instructions/Additional Testing Requests

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