Requisition Form – Prenatal Diagnosis

INVITAE | CombiMatrix

Client Information

Referring Physician _____ NPI _____

Ordering 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: ❑ Institution ❑ Insurance ❑ Medicare ❑ Medicaid ❑ Patient

Insurance Information ❑ See attached

Insured Information Name _____

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

Primary Insurance Co. _____ Authorization # _____

Billing Address _____ Insured # _____

Billing City, State, Zip _____ Group # _____

Secondary Insurance Co. _____ Authorization # _____

Billing Address _____ Insured # _____

Billing City, State, Zip _____ Group # _____

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 copayments 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)

Prenatal Testing

Collection Date _____ # Tubes _____

Specimen ID #(s) _____

Sample Type

❑ Chorionic villi ❑ Amniotic fluid ❑ Parental blood ❑ Other: _____

❑ Cultured CVS ❑ Cultured amniocytes ❑ DNA Source: _____

Pregnancy History

Gestational age: _____ wks _____ days by ❑ LMP ❑ U/S

Gravida _____ Para _____ SAB _____ TAB _____

Is the pregnancy currently ongoing? ❑ Yes ❑ No, SAB/IUFD ❑ No, TAB

How many fetuses? ❑ 1 ❑ 2 ❑ 3

Fetal gender: ❑ Female ❑ Male ❑ Unknown

Fetal karyotype: ❑ 46,XX ❑ 46,XY ❑ Not performed ❑ Pending ❑ Abnormal*

NIPT results: ❑ Not performed ❑ Normal ❑ Abnormal*

*** If fetal karyotype and/or NIPT results are ABNORMAL, please enclose a copy of the report(s) ****

Prenatal Indications

❑ Advanced maternal age: ○ primagravida (O09.519) ○ multigravida (O09.529)

❑ Abnormal maternal serum screening/NIPT suggestive of a fetal chromosomal abnormality (O28.5)

❑ Abnormal maternal serum screening suggestive of a neural tube defect (O28.1)

❑ Other abnormal findings on antenatal screening of mother (O28.8)

❑ Abnormal fetal ultrasound (O28.3); Specify abnormality: _____

*** Please indicate abnormalities on the Phenotypic Checklist provided with the CombiMatrix Kits ****

❑ Other _____ ICD-10 _____

Prenatal Testing Options – CVS and Amniocentesis

❑ Amniotic fluid AFP with reflex to AChE (amniocentesis only)

❑ CombiFISH™ (interphase FISH for 13, 18, 21, X, Y)
(must order karyotype or microarray in addition to CombiFISH for confirmation)

❑ CombiSNP™ microarray analysis
- ○ CombiSNP™ Whole Genome Array (with confirmation FISH when indicated)
- ○ CombiSNP™ Targeted Prenatal Array (with confirmation FISH when indicated)

Reflex to karyotype if microarray is normal? ❑ Yes ❑ No

❑ Karyotype
Reflex to microarray (on cultured cells) if karyotype is normal? ❑ Yes ❑ No
- ○ CombiSNP™ Whole Genome Array (with confirmation FISH when indicated)
- ○ CombiSNP™ Targeted Prenatal Array (with confirmation FISH when indicated)

Parental/ Familial Studies

For parental or family studies, please complete the Parental and Family Studies Test Requisition form. You can access this and other forms on our website at: www.combimatrix.com/providers/forms.

Special Instructions/Additional Testing Requests

For any testing requests not listed on this form, please contact one of our Genetic Counselors at 949.255.0921 to arrange testing. Please note that that most reference laboratories require proper supporting documentation of the specific familial mutation, as well as a maternal blood sample to test for maternal cell contamination.

Phenotypic Checklist – Prenatal

INVITAE | CombiMatrix

The accurate interpretation and reporting of genetic results relies on the provision of pertinent clinical and family history information. To help ensure the most clinically appropriate interpretation of results, please complete this clinical information form. Testing cannot be initiated without a reason for referral.

Please Check All That Apply

Primary Indication for Testing
- ❑ Abnormal screening results:
  - ❑ Abnormal NIPT result (please include report): _____
  - ❑ Abnormal serum screen: _____
  - ❑ Increased NT/cystic hygroma
- ❑ Advanced maternal age
- ❑ Fetal abnormality

Growth
- ❑ Hydrops
- ❑ IUGR
- ❑ Macrosomia
- ❑ Molar pregnancy
- ❑ Oligohydramnios
- ❑ Placental abnormality
- ❑ Polyhydramnios
- ❑ Single umbilical artery/2 vessel cord
- ❑ Other: _____

Gastrointestinal
- ❑ Anal atresia
- ❑ Absent stomach
- ❑ Duodenal atresia (double bubble sign)
- ❑ Echogenic bowel
- ❑ Gastroschisis
- ❑ Omphalocele
- ❑ Tracheoesophageal fistula
- ❑ Other: _____

Craniofacial
- ❑ Cleft lip and/or cleft palate
- ❑ Hypertelorism
- ❑ Hypotelorism
- ❑ Macrocephaly
- ❑ Microcephaly
- ❑ Micrognathia
- ❑ Pierre Robin sequence
- ❑ Other: _____

Pulmonary
- ❑ CCAM
- ❑ Diaphragmatic hernia
- ❑ Eventration of diaphragm
- ❑ Pleural effusion
- ❑ Pulmonary sequestration
- ❑ Small thoracic cavity
- ❑ Other: _____

Cardiac
- ❑ Aortic atresia
- ❑ Atrial septal defect (ASD)
- ❑ AV canal defect
- ❑ Coarctation of aorta
- ❑ Ebstein anomaly
- ❑ Echogenic intracardiac focus
- ❑ Hypoplastic left heart
- ❑ Hypoplastic right heart
- ❑ Pericardial effusion
- ❑ Pulmonary atresia
- ❑ Tetralogy of Fallot
- ❑ Transportation of the great vessels
- ❑ Truncus arteriosus
- ❑ Ventricular septal defect (VSD)
- ❑ Other: _____

Neurological
- ❑ Abnormal gyri/Lissencephaly
- ❑ Agenesis of the corpus callosum
- ❑ Cerebellar hypoplasia
- ❑ Choroid plexus cyst(s)
- ❑ Dandy Walker (posterior fossa abn.)
- ❑ Decreased fetal movement
- ❑ Holoprosencephaly
- ❑ Open neural tube defect (ONTD)
  - ❑ Anencephaly
  - ❑ Spina bifida
- ❑ Structural brain anomaly
- ❑ Ventriculomegaly/hydrocephaly
- ❑ Other: _____

Musculoskeletal
- ❑ Contractures (arthrogryposis)
- ❑ Club Foot
- ❑ Limb anomaly (lower)
- ❑ Limb anomaly (upper)
- ❑ Polydactyly (feet)
- ❑ Polydactyly (hands)
- ❑ Rocker-bottom feet
- ❑ Scoliosis
- ❑ Shortened long bones
- ❑ Skeletal dysplasia
- ❑ Syndactyly (feet)
- ❑ Syndactyly (feet)
- ❑ Vertebral anomaly

Genitourinary
- ❑ Ambiguous genitalia
- ❑ Hydronephrosis
- ❑ Megacystis
- ❑ Pyelectasis
- ❑ Polycystic kidneys
- ❑ Renal agenesis
- ❑ Urethral/ureteral obstruction

Family History
- ❑ Patient has had ≥2 miscarriages
- ❑ Previous pregnancy with chromosome abnormality: _____
- ❑ Family history of known chromosome abnormality/genetic condition: _____
- ❑ Other (please describe) _____

Other
_____

_____

_____

As a participant in the International Collaboration for Clinical Genomics (ICCG), this clinical cytogenetics laboratory contributes submitted clinical information and test results to a HIPAA compliant, de-identified public database as part of the NIH's effort to improve understanding of the relationship between genetic changes and clinical symptoms. Confidentiality is maintained.

Patients may request to opt out of this scientific effort by 1) checking the box below or 2) calling the laboratory at 800.710.0624 and asking to speak with a laboratory genetic counselor. Please call with any questions.

❑ Mark here to indicate refusal for inclusion in these efforts by checking this box. If the box is not marked, data will be anonymized and submitted.

Testing Notes

CombiMatrix will attempt to perform all tests ordered. If the sample size is insufficient to do so, CombiMatrix will perform testing according to a predefined standing order contingency plan. If no standing order contingency plan exists, CombiMatrix will promptly notify the client and discuss what testing can and cannot be performed. If CombiMatrix is unable to make contact with a client the same day (the day the sample was received) to determine what testing is desired, CombiMatrix will run only the tests that are possible based on the sample received. To set up a standing order contingency plan, please contact CombiMatrix's Director of Genetic Counseling Services at 800.710.0624 option 3.

If testing other than the options listed on this form is desired, please contact one of CombiMatrix's genetic counselors to discuss whether it is possible to accommodate your request prior to sending the sample. If prior arrangements are not made, CombiMatrix cannot guarantee the ability to provide the requested testing.

Patient Information

Please place the completed label from the Test Requisition Form with the patient information here and return this form with the test sample:

_____ | _____ | _____
MM DD YY
Specimen Collection Date

_____ | _____ | _____
Patient DOB

_____
Last Name

_____
First Name

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