INVITAE

ORDER ID
For Invitae internal use only

INVITAE PRENATAL DIAGNOSIS REQUISITION FORM

PATIENT INFORMATION

First name	MI	Last name	Date of birth (MM/DD/YYYY)	Biological sex ◯ Male ◯ Female	MRN (medical record number)

Email address	Mobile phone	Ancestry: ◯ Asian ◯ Black/African American ◯ White/Caucasian ◯ Ashkenazi Jewish ◯ Hispanic ◯ Native American ◯ Pacific Islander ◯ French Canadian ◯ Sephardic Jewish ◯ Mediterranean ◯ Other: _____

Address	City	State/Prov	Zip/Postal code	Country

ORGANIZATION INFORMATION

Organization name	Phone	Fax

Address	City	State/Prov	Zip/Postal code	Country

Primary clinical contact name (contact for general inquiries)	Phone	Fax	Email address

Ordering physician name	NPI	Phone	Fax	Email address

Referring physician name	Phone	Fax	Email address

Additional clinical or laboratory contact name	Fax	Email address

INSURANCE BILLING (attach front and back of insurance card)

Attach applicable clinical notes and medical records. We do not accept insurance for patients outside the US. www.invitae.com/billing

Policyholder name	Patient relationship to policyholder ◯ Self ◯ Spouse ◯ Child ◯ Other: _____	Indicate ICD-10 code in Reason for testing

Primary insurance company name	Primary member ID #	Primary insurance phone	Prior-authorization #

Secondary insurance company name	Secondary member ID #	Secondary insurance phone	Prior-authorization #

PATIENT PAY BILLING

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

INSTITUTIONAL BILLING

Invitae will send an invoice to the organization listed above.

Collection date: _____/_____/_____ **# tubes:** _____ **Specimen ID#s:** _____

PRENATAL DIAGNOSIS

MICROARRAY ANALYSIS

◯ Invitae Prenatal Chromosomal Microarray Analysis (with follow-up FISH when required)
◯ Invitae Prenatal Targeted Chromosomal Microarray Analysis (with follow-up FISH when required)
◯ If microarray is normal, reflex to Invitae Prenatal Karyotype (Chromosome Analysis)

KARYOTYPE

◯ Invitae Prenatal Karyotype (Chromosome Analysis)
◯ If karyotype is normal, reflex to Invitae Prenatal Chromosomal Microarray Analysis (with follow-up FISH when required)
◯ If karyotype is normal, reflex to Invitae Prenatal Targeted Chromosomal Microarray Analysis (with follow-up FISH when required)

ADDITIONAL TESTING (must order microarray or karyotype first)

◯ Invitae Prenatal Interphase FISH (for 13, 18, 21, X, Y)
◯ Amniotic fluid AFP with reflex to AChE (if over 24 weeks gestational age only AChE will be performed)
◯ Culture cells for additional testing (provide details in special instructions below)

Specimen type:
◯ Chorionic villi ◯ Amniotic fluid ◯ DNA source: _____
◯ Cultured CVS ◯ Cultured amniocytes ◯ Other: _____

Reason for testing (select all that apply):
◯ O09.519 Advanced maternal age (1st pregnancy)
◯ O09.529 Advanced maternal age (subsequent pregnancy)
◯ O28.5 Abnormal chromosomal and genetic finding on antenatal screening of mother
◯ O28.1 Abnormal maternal serum screening suggestive of a neural tube defect
◯ O28.8 Other abnormal findings on antenatal screening of mother
◯ O28.3 Abnormal fetal ultrasound; Specify abnormality: _____
Indicate abnormalities on Page 2 Phenotypic Checklist
◯ Other ICD-10: _____

Pregnancy history:
Gestational age Wks:_____ Days: _____ Determined 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 sex: ◯ Female ◯ Male ◯ Unknown
Fetal karyotype: ◯ 46,XX ◯ 46,XY ◯ Not performed ◯ Pending ◯ Abnormal*
NIPS results: ◯ Not performed ◯ Normal ◯ Abnormal* **enclose copy of report*
If NIPS was performed at Invitae, provide Order ID: RQ _____

Special instructions/additional requests:

MATERNAL CELL CONTAMINATION

◯ Maternal Cell Contamination following Prenatal Testing
ICD-10: _____

Specimen type: Blood
4-mL purple EDTA tube

PARENTAL FOLLOW-UP

◯ Invitae Parental Chromosomal Microarray Analysis
◯ Invitae Parental FISH Analysis
◯ Invitae Parental Karyotype (Chromosome Analysis)

Specimen type: Blood
4-mL purple EDTA and
4-mL green NaHep tubes

Previous testing:
◯ Previous testing was performed at Invitae/Combimatrix - provide previously tested info:
Invitae accession#: _____ Relationship to patient: _____
Full name: _____ DOB: _____
◯ Previous testing was performed at another lab:
◯ Report is available - include copy with sample shipment
◯ Report is not available - call Invitae genetic counseling 800-436-3037 to confirm testing

Reason for testing (select all that apply):
Evaluation of genetic disease carrier status for procreative management ◯ Z31.430 Female ◯ Z31.440 Male
◯ Z82.79 Family history of a chromosome abnormality ◯ Other ICD-10: _____

RECURRENT PREGNANCY LOSS OR INFERTILITY

◯ Invitae Reproductive Karyotype (Chromosome Analysis)

Specimen type: Blood
4-mL purple EDTA and 4-mL green NaHep tubes

Reason for testing (select all that apply):
◯ N97.9 Female infertility, unspecified ◯ N96 Female recurrent pregnancy loss
◯ N46.9 Male infertility, unspecified ◯ Z31.441 Male partner of patient with recurrent pregnancy loss

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 (www.invitae.com/cytogenomic-consent), 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 the Patient has agreed that if the Patient's insurer does not reimburse Invitae in full for any reason, including if the insurer considers the genetic test ordered to be a non-covered service or not medically necessary, then Invitae may bill the Patient directly for the services and the Patient will remit payment directly to Invitae. 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 (required)	Date

INVITAE

Patient's first name _____ Patient's last name _____

INVITAE PRENATAL PHENOTYPIC CHECKLIST

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, 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 (hands)
- ○ 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: _____ _____

Other (describe below)

_____ _____

Testing notes

Invitae will attempt to perform all tests ordered. If the sample size is insufficient to do so, Invitae will promptly notify the client and discuss what testing can and cannot be performed. If Invitae is unable to make contact with a client the same day (the day the sample was received) to determine what testing is desired, Invitae will run only the tests that are possible based on the sample received.