Prenatal Requisition Form

Pacific Rim PATHOLOGY
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Patient Information (Attach face sheet or label when available)

Last name: | First name: | MI | DOB: | Sex: | Patient ID/MR #: | Specimen ID #

Address: | City/State: | Zip | Phone: | Fax: | Patient FIN #

Account / Ordering Clinician

Reporting to: | Genetic counselor:

Account name: | Account #:

Address: | City: | State: | Zip

Ordering Clinician Name: | Phone: | Fax:

Referring Physician / Additional

Healthcare Provider Name:

Address:

City/State: | Country: | Zip:

Phone: | Fax:

Billing Information (Prior authorization may be required by certain Insurance Carriers):

☐ Private insurance (Attach face sheet / insurance card when available) Relationship of patient to insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Last name: | First name: | Member ID:

Group #: | Primary insurance: | Prior authorization #:

Specimen Collection: DATE: _____ (Month) - _____ (Day) - _____ (Year) TIME: _____AM/ PM

Test Menu Options

CHOOSE EITHER TEST (Verifi® or Verifi Plus®) AND ALL OPTIONS THAT APPLY):*

Verifi Prenatal Test (chromosomes 21, 18, 13)

☐ Singleton	☐ Twin
Additional option: ☐ Sex chromosome aneuploidies (MX, XXX, XXY, and XYY)	Additional option: ☐ Presence of Y chromosome

OR

Verifi Plus Prenatal Test (chromosomes 21, 18, 13)

Singleton

Additional options:

☐ Microdeletions:
1p36 deletion, 4p- (Wolf-Hirschhorn syndrome), 5p- (cri-du-chat syndrome), 15q11.2 (Prader-Willi syndrome/ Angelman syndrome), 22q11.2 deletion (DiGeorge syndrome)

☐ Sex chromosome aneuploidies (MX, XXX, XXY, and XYY)

☐ All chromosomes (including sex chromosome aneuploidies [MX, XXX, XXY, and XYY])

verifi® by Pacific Rim

Test Indications

Choose at least one:

☐ Advanced Maternal Age > (35 years)

☐ Positive Serum Screen

☐ Abnormal Ultrasound

☐ Hx suggestive of increased risk for the specified chromosome aneuploidies

☐ Low risk/maternal anxiety

☐ Other_____

Clinical Information

Gestational Age: wks/days or mm/dd/yyyy

Dating method: ☐ LMP ☐ CRL ☐ Date of implantation ☐ Other_____

Date of draw: mm/dd/yyyy

Maternal height: ☐ cm ☐ ft in

Maternal weight: ☐ kgs ☐ lbs

Client sample ID:

Comments:

This prenatal test is validated for singleton and twin pregnancies with gestational age of at least 10 weeks 0 days, as estimated by last menstrual period, crown rump length, or other appropriate method (equivalent to 8 weeks fetal age as determined by date of conception).

I certify that (i) this test is medically necessary, (ii) the patient (or authorized representative on the patient's behalf) has given informed consent (which includes written informed consent or written authorization when required by law) to have this testing performed, and (iii) the informed consent obtained from the patient meets the requirements of applicable law and Illumina's Patient Informed Consent. I agree to provide Illumina, or its designee, any and all additional information reasonably required for this testing to be performed.

Healthcare provider signature:_____ Date: _____

Specimen Transport : ☐ Room Temp ☐ Refrigerated ☐ Frozen

Specimen Type: ☐ Whole Blood ☐ FFPE Block ☐ Fresh Tissue ☐ FFPE Slides ☐ Chorionic villi ☐ Other

POSTNATAL SAMPLES

Specimen ID #(s) _____

☐ **Miscarriage Analysis testing: Whole Genome Array HD**

Pregnancy History: Gravida _____Para _____ SABs _____TABs _____
How many fetuses? 1 2 3 Gestational Age: _____wks _____days ☐ unknown
Fetal gender: ☐ Female ☐ Male ☐ Unknown
Fetal Karyotype: ☐ 46, XX ☐ 46, XY ☐ Not performed ☐ Pending ☐ Abnormal

Miscarriage Analysis Indications:
☐ Recurrent pregnancy loss (N96) ☐ Intrauterine fetal demise (036.4XX0)
☐ Miscarriage/SAB (003.9) ☐ Therapeutic abortion/TAB (Z33.2)
☐ Missed Abortion (002.1) ☐ Other _____ ICD-10_____

** Submit a Patient Clinical Information Form and Informed Consent Form

PHONE/FAX RESULTS (Required) ☐ PHONE ☐ SECURE FAX

( )_____ number

_____ Contact name (last, first)

Pacific Rim Pathology is part of Consortium and submits de-identified 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 efforts by checking the box below. Call Pacific Rim at (858) 795-8800 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.

PATIENT CONSENT: By signing this form, I, the patient having this screening performed, acknowledge that: (i) I have been offered the opportunity to ask questions and discuss with my health care provider the benefits, risks, and limitations of the test to be performed; (ii) I have discussed the test limitations (reliability of positive and negative test results; the predictive value of the test results; and that the test is not a diagnostic test, but a screening test and is not definitive) with the health care provider who ordered the test; (iii) I have been informed about the availabilityand importance of genetic counseling and have been provided with information identifying an appropriate health care provider from whom I might obtain such counseling; (iv) I have received, read, and understood the Patient Informed Consent in its entirety and that I may retain a copy for my records; (v) I consent to the use of the leftover specimen and health information as described in the Patient Informed Consent; (vi) I consent to having this testperformed; and (vii) I will discuss the results and appropriate medical management with my health care provider.

Patient signature: **Date:**

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