

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

Referring Physician / Additional

Reporting to: Genetic counselor:	Healthcare Provider Name:
Account name: Account #:	Address:
Address: City: State: Zip	City/State: Zip:
Ordering Clinician Name: Phone: Fax:	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: Phone/Fax Results (Required) PHONE SECURE FAX

DATE: _____ TIME: _____ AM/ PM () _____ number Contact name (last, first)

Month Day Year

Test Menu Options	Test Indications	Clinical Information
<p>CHOOSE EITHER TEST (Verifi™ or Verifi™ Plus) AND ALL OPTIONS THAT APPLY:</p> <p style="text-align: center;">Verifi™ Prenatal Test (chromosomes 21, 18, 13)</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Singleton Additional option: <input type="checkbox"/> Sex chromosome aneuploidies (MX, XXX, XXY, and XYY) </div> <div style="width: 45%;"> <input type="checkbox"/> Twin Additional option: <input type="checkbox"/> Presence of Y chromosome </div> </div> <p style="text-align: center;">OR</p> <p style="text-align: center;">Verifi™ Plus Prenatal Test (chromosomes 21, 18, 13)</p> <div style="border: 1px solid black; padding: 5px;"> <p style="text-align: center;">Singleton</p> Additional options: <input type="checkbox"/> Microdeletions: 1p36 deletion, 4p- (Wolf-Hirschhorn syndrome), 5p- (cri-du-chat syndrome), 15q11.2 (Prader-Willi syndrome/ Angelman syndrome), 22q11.2 deletion (DiGeorge syndrome) <input type="checkbox"/> Sex chromosome aneuploidies (MX, XXX, XXY, and XYY) <input type="checkbox"/> All chromosomes (including sex chromosome aneuploidies) [MX, XXX, XXY, and XYY] (additional charge to patient for this option) </div> <p style="text-align: right; font-size: small;">verifi™ by Pacific Rim</p>	<p>Choose at least one:</p> <input type="checkbox"/> Advanced Maternal Age > (35 years) <input type="checkbox"/> Positive Serum Screen <input type="checkbox"/> Abnormal Ultrasound <input type="checkbox"/> Hx suggestive of increased risk for the specified chromosome aneuploidies <input type="checkbox"/> Low risk/maternal anxiety <input type="checkbox"/> Other _____	<p>Gestational Age: _____ <i>wks/days or mm/dd/yyyy</i></p> <p>Dating method: <input type="checkbox"/> LMP <input type="checkbox"/> CRL <input type="checkbox"/> Date of implantation <input type="checkbox"/> Other _____</p> <p>Date of draw: <i>m m / d d / y y y y</i></p> <p>Maternal height: <input type="checkbox"/> cm <input type="checkbox"/> ft in</p> <p>Maternal weight: <input type="checkbox"/> kgs <input type="checkbox"/> lbs</p> <p>Client sample ID: _____</p> <p>Comments: _____</p> <p style="font-size: x-small;">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).</p>

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 :	<input type="checkbox"/> Room Temp	<input type="checkbox"/> Refrigerated	<input type="checkbox"/> Frozen
Specimen Type:	<input type="checkbox"/> Whole Blood	<input type="checkbox"/> Fresh Tissue	<input type="checkbox"/> Chorionic villi
	<input type="checkbox"/> FFPE Block	<input type="checkbox"/> FFPE Slides	<input type="checkbox"/> 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:

<input type="checkbox"/> Recurrent pregnancy loss (N96)	<input type="checkbox"/> Intrauterine fetal demise (O36.4XX0)
<input type="checkbox"/> Miscarriage/SAB (003.9)	<input type="checkbox"/> Therapeutic abortion/TAB (Z33.2)
<input type="checkbox"/> Missed Abortion (002.1)	<input type="checkbox"/> Other _____ ICD-10 _____

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

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 availability and 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 test performed; and (vii) I will discuss the results and appropriate medical management with my health care provider.

Patient signature: _____ Date: _____