Genetic Testing: Noninvasive Prenatal Screening and Carrier Screening Requisition Form

HNL Lab Medicine

CLIA# 39D1027912 794 Roble Road | Allentown, PA 18109
CAP# 7190738 P: +1 484-244-2900 | F: +1 484-425-5846 | Customer Care: +1 877-402-4221

PATIENT INFORMATION

First Name	Last Name	
Sex ☐ Male ☐ Female Gender (optional): _____	Date of Birth (MM/DD/YYYY)	Last 4 Digits of SS #
Address		
City	State	Zip Code
Email		
Primary Phone	Cell Phone	

Patient Status – one must be checked:

□ Hospital Outpatient ☐ Hospital Inpatient – Date of Discharge: _____

□ Not a Hospital Patient

BILLING INFORMATION

Bill to: ☐ Client ☐ Patient (Self-Pay) ☐ Patient Insurance

PATIENT INSURANCE INFORMATION

Please include copy of insurance card (front/back)

MEMBER NAME		
DATE OF BIRTH (MM/DD/YYYY)	RELATIONSHIP TO PATIENT	
MEMBER POLICY NUMBER	MEMBER GROUP NUMBER	
INSURANCE COMPANY NAME	INSURANCE COMPANY PHONE	
INSURANCE COMPANY ADDRESS		
CITY	STATE	ZIP CODE
PRIOR AUTHORIZATION # (IF APPLICABLE)	FAP REFERENCE # (IF APPLICABLE)	

REQUIRED PRIOR AUTHORIZATION INFORMATION

Please attach/include:

- Copy of Insurance Card
- Relevant Clinical Notes, Test Reports (i.e. ultrasound findings, family genetic pedigree)
- Sample
- Completed Requisition Form

PATIENT AUTHORIZATION/ASSIGNMENT

☐	I AUTHORIZE HNL Lab Medicine to retain and use my de-identified specimen and test data (where all information that could link me to the specimen or data has been removed) for research and/or help develop new products or services, in compliance with applicable laws.
☐	I DO NOT AUTHORIZE HNL Lab Medicine to retain and use my de-identified specimen and test data as described above. If a signature is present but box is not checked, consent is implied. All leftover specimens from New York State will be destroyed within 60 days
☐	I AUTHORIZE HNL Lab Medicine to contact me via email, cellular or home phone, text message, or computer assisted technology for billing matters.
☐	I AUTHORIZE HNL Lab Medicine to obtain and release relevant medical and other information to Medicare, Medicaid, Medicare Supplemental and any other insurance providers for laboratory services provided to me.

PATIENT/GUARDIAN SIGNATURE: DATE (MM/DD/YYYY):

Required _____ _____

PATIENT SCREENING INFORMATION

ORDER DATE (MM/DD/YYYY)	COLLECTION DATE (MM/DD/YYYY)		
IS THE PATIENT CURRENTLY PREGNANT? ☐ Yes ☐ No			
NAME OF LEGAL GUARDIAN IF PATIENT IS A MINOR			
PATIENT ETHNICITY ☐ Asian ☐ African American ☐ White/Caucasian	☐ French Canadian/Cajun ☐ Hispanic ☐ Jewish, Ashkenazi	☐ Jewish, Non-Ashkenazi ☐ Middle Eastern ☐ Native American	☐ Other _____
DOES THE PATIENT HAVE A KNOWN FAMILY HISTORY OF GENETIC DISEASE? ☐ YES ☐ NO			
IF YES TO ABOVE, INCLUDE RELEVANT FAMILY HISTORY			
THE FOLLOWING FIELDS ARE REQUIRED FOR NIPS ORDERS:			
IS THERE AN INCREASED RISK OF CHROMOSOMAL ABNORMALITIES? (EX. POSITIVE SERUM SCREEN, ULTRASOUND FINDINGS, PRIOR PREGNANCY WITH TRISOMY, ETC.)			
SAMPLE TYPE ☐ Singleton ☐ Twin	ESTIMATED DATE OF DELIVERY (EDD)	MATERNAL WEIGHT	

REPORTING INFORMATION

ORDERING HEALTH CARE PROFESSIONAL

NAME		NPI NUMBER
TITLE / ROLE		
GENETIC COUNSELOR		
INSTITUTION		
TELEPHONE NUMBER	FAX NUMBER	
E-MAIL		
STREET NUMBER	STREET NAME	SUITE NUMBER
CITY	STATE	ZIP
COPY RESULTS TO NAME	COPY RESULTS TO FAX	

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REPORTING INFORMATION

ADDITIONAL REPORTS

REFERRING LAB	REFERRING LAB ID#
CONTACT PERSON	
TELEPHONE NUMBER	FAX NUMBER
E-MAIL	
STREET NUMBER / STREET NAME / SUITE NUMBER	
CITY / STATE / ZIP	

ACKNOWLEDGEMENT: I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given consent as required under applicable laws and regulations for the test(s) to be performed. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purposes for this patient. I confirm that the person listed as the Ordering Clinician is authorized by law to order the tests(s) requested herein.

PROVIDER SIGNATURE DATE (MM/DD/YYYY)

Required

INDICATION FOR TESTING

ICD-10 CODE(S): (REQUIRED)

TEST CODES:

HOW WILL THE RESULT OF THIS TEST INFLUENCE THE MANAGEMENT OF PREGNANCY, DIAGNOSIS, OR THE PATIENT'S TREATMENT PLAN?

ADDITIONAL INFORMATION

PLEASE PROVIDE ANY OTHER RELEVANT INFORMATION (IVF PREGNANCY, EGG DONOR, RECENT MATERNAL BLOOD TRANSFUSION, ETC.)

NONINVASIVE PRENATAL SCREENING (NIPS)

TEST CODE	TEST OPTION
☐ NIPT	Trisomy 21, 18, and 13 screening ☐ Report fetal sex and X and Y aneuploidy ☐ DO NOT report fetal sex and X and Y aneuploidy If no fetal sex reporting option is selected, the test will automatically default to NOT report fetal sex and X and Y aneuploidy NOTE: FOR NIPS TESTING, PATIENT SHOULD NOT BE DRAWN BEFORE **10 WEEKS** GESTATIONAL AGE

CARRIER SCREENING TESTS

PANEL TESTING

TEST CODE	DISORDER / PANEL	GENES
☐ 6000	Common Carrier Screening Panel	ASPA, BCKDHA, BLM, CFTR, DMD, ELP1, FANCC, FMR1, GBA, HBA1, HBA2, HBB, HEXA, MCOLN1, PAH, SMN1, SMN2, SMPD1
☐ 6001	Extended Carrier Screening Panel	ACADM, ARSA, ARSB, ASPA, ASS1, BCKDHA, BCKDHB, BLM, BTD, CFTR, DHCR7, DMD, ELP1, FANCC, FMR1, G6PC, GAA, GALC, GALE, GALK1, GALT, GAMT, GATM, GBA, GLA, HBA1, HBA2, HBB, HEXA, IDS, IDUA, IVD, MCOLN1, MMACHC, OTC, PAH, PHKA2, PHKG2, PKHD1, PYGL, SLC37A4, SLC6A8, SMN1, SMN2, SMPD1, SUMF1

RELATED CARRIER SCREENING TESTS

☐ 6002	Cystic fibrosis	CFTR
☐ 6003	Duchenne muscular dystrophy, Becker muscular dystrophy, Dilated Cardiomyopathy 3B	DMD
☐ 6004	Fragile X syndrome, Fragile X tremor/ataxia syndrome, Premature ovarian failure 1	FMR1
☐ 6005	Alpha Thalassemia	HBA1, HBA2
☐ 6006	Sickle Cell Anemia, Beta Thalassemia	HBB
☐ 6007	Phenylketonuria	PAH
☐ 6008	Spinal muscular atrophy	SMN1, SMN2

Any gene in the Carrier Screening panels can be run as a single disorder test

Please fill out the above information and sign. This form should be submitted with the specimen to 794 Roble Road, Allentown, PA, 18109.