GENESYS Diagnostics INC.

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Email: info@gdilabs.com

CT-ST License # CL-0687

Women's Health, Prenatal & Constitutional Requisition Form

1: PATIENT INFORMATION

Billing # Client # FOR STAT SAMPLES All or Single Test ☐ Call to (check below) ☐ Your facility ☐ Alternate Number ( )_____	PATIENT NAME (LAST) (FIRST) (M.I.)	Electronic Medical Record #	BIRTH DATE (Month/Day/Year)
	PATIENT ADDRESS (STREET) CITY STATE ZIP		
	PATIENT PHONE # ☐ Male ☐ Female		
	Date & Time Collected:	Drawn By:	
Ordering Physician Name & Signature	☐ MEDICARE PRIMARY ☐ MEDICARE SECONDARY MEDICARE/MED. NUMBER STATE MEDICAL ASSISSTANCE NUMBER STATE		
Genetic Counselor	POLICY HOLDER NAME / POLICY HOLDER DATE OF BIRTH / MEMBER/POLICY # / GROUP #		
	RELATIONSHIP OF PATIENT TO INSURED ☐ SELF ☐ SPOUSE ☐ DEPENDENT / INSURANCE CO. NAME		
Phone: **Fax:**	**ICD DIAGNOSIS CODE(S) FOR TESTS ORDERED (MUST BE PROVIDED)** **Dx1** / **Dx2** / **Dx3** / **Dx4**		

2: SPECIMEN TYPE

☐ Amniotic Fluid ☐ Chorionic Villi (CVS) ☐ Peripheral Blood ☐ Placenta ☐ Product of Conception/ Autopsy ☐ Pubs Blood
☐ Skin Biopsy ☐ Tissue ☐ Other _____

3: PRENATAL TEST INFORMATION (Required)
Ultrasound gestation = ---------- Gravida --------- Parity---------- Spontaneous Abortion---------- Therapeutic Abortion ----------

4: TESTING INDICATIONS

☐ Advanced Maternal Age (O09.519)
☐ Abnormal Maternal Serum Screen (O28.9)
☐ Abnormal Ultrasound (O28.3)
☐ Developmental Delay (F88)
☐ Autism Spectrum (F84.0)
☐ Supervision, normal 1st pregnancy (Z34.00)
☐ Supervision, other normal pregnancy (Z34.80)
☐ Dysmorphic features (Q18.9, Q79.9)
☐ Multiple Abortions/ Miscarriages (O03.9)
☐ Consanguinity (Z84.3)
☐ Other:
☐ Family History of Related Disorder (Z84.99)
Please Describe:

5: PRENATAL TESTING (*SENDOUT*)

☐ AFP (alphafetoprotein) ☐ ACHE (acetylcholinesterase) ☐ Other Sendout

6: CHROMOSOME ANALYSIS ☐ Yes ☐ No Please Check One

7: FISH STUDIES (circle one) → RUN OR HOLD

FISH FOR ANEUPLOIDY
☐ (AneuVysion) X/Y/18/13/21
☐ X/Y/18 ONLY
☐ 13/21 ONLY
☐ Trisomy 21 - Down Syndrome
☐ Trisomy 18 - Edwards Syndrome
☐ Trisomy 13 - Patau Syndrome

FISH FOR SEX CHROMOSOME ABNORMALITIES:
☐ Sex Determination (X/SRY)
☐ Turner Syndrome (CEPX/CEPY)
☐ Klinefelter Syndrome (CEPX/CEPY)

FISH FOR MICRODELETION SYNDROMES

☐ Angelman syndrome	15q11-13	☐ Soto syndrome	5q35
☐ Cri du Chat-syndrome	5p15.2	☐ SRY	Yp11.3
☐ DiGeorge/VCFS/CATCH22	22q11.2	☐ Steroid Sulfatase (STS)	Xp22.3
☐ Kallmann syndrome	Xp22.3	☐ Wolf-Hirschhorn syndrome	4p16.3
☐ Miller-Dieker syndrome	17p13.3	☐ Williams Beuren syndrome	7q11.23
☐ Prader-Willi syndrome	15q11-13	☐ XIST	Xq13.2
☐ Smith-Magenis syndrome	17p 11.2	☐ Other _____	

8: MICROARRAY ANALYSIS ☐ Yes ☐ No Please Check One

9: OTHER SCREENING TESTS PROVIDED (IN EDTA tubes)

☐ Cystic Fibrosis ☐ Fragile X Syndrome ☐ Spinal Muscular Atrophy

10: HEALTHCARE PROVIDER AUTHORIZATION

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 Genesys's Patient Informed Consent. I agree to provide Genesys, or its designee, any and all additional information reasonably required for this testing to be performed.

Signature of Healthcare Provider (Required) _____ Date (Required) _____

11: PATIENT BILLING INFORMATION:

PLEASE INCLUDE A COPY OF THE INSURANCE CARD(S) FOR BILLING PURPOSES

☐ **CLIENT BILL**	☐ **INSURANCE**	☐ **MEDICARE/MEDICAID**	☐ **SELF PAY**

12: PATIENT AUTHORIZATION

I understand that I am responsible for providing accurate information about my insurance to Genesys Diagnostics Inc. I understand that Genesys Diagnostics Inc. will be providing testing service and billing my insurance. However, I understand that charges that are not covered by my insurance, including any applicable co-payments and deductibles are my responsibility and I agree to pay such charges promptly.

Signature of Patient/Responsible Party (Required)_____ Date (Required)_____

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☐ Authorization signature is on file

Patient Informed Consent

PATIENT CONSENT (Required for New York and Massachusetts Patients)*

By signing this form, I, the patient having the testing performed, or the patient authorized individual acknowledged that: (i) I have been offered the opportunity to ask questions and discuss with my healthcare provider the benefits, risks, and limitations of the test to be performed; (ii) I have discussed with the healthcare provider ordering this test the reliability of positive or negative test results and the level of certainty that a positive test result for a given disease or condition serves as a predictor of that disease or condition; (iii) I have been informed identifying an appropriate healthcare provider from whom I might obtain such counseling; (iv) I have received and read the Patient Informed Consent in its entirety and realize 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 I will discuss the results and appropriate medical management with my healthcare provider.

Signature of Patient (Required) _____ Date (Required)_____

Introduction: This form describes the benefits, risks, and limitations of these tests. You should seek genetic counseling prior to undergoing this testing. Read this form carefully before making your decision about testing.

Purpose: The purpose of these tests are to evaluate the genetic material of the fetus. Your healthcare provider has determined that this test is appropriate for you. Consult your healthcare provider for more information about this test, including the limitations and risks, performance data, and error rates, descriptions of the mutations and variants, and what the test results may mean to you.

How this Test Works: This test analyzes the DNA (genetic material) for structural and/or numerical abnormalities in various sample types. A positive result is an indication that the individual may be predisposed to, have the specific disease or condition, or risk passing mutations to children and may want to consider further independent testing, consult their physician, or pursue genetic counseling.

Limitations of the Test: Normal test results do not rule out other possible genetic conditions. This test, like many tests, has limitations including, false positive and false negative rates. This means that the mutation being tested for, may be present even though it was not really present (this is called a "false negative"); Positive results are highly indicative of the presence of a genetic abnormality. Further testing of the pregnancy and in some cases you, may be needed to confirm your test results which could result in additional expense. We recommend that no irreversible clinical decisions be made based on these results alone. Consult your healthcare provider for more information about the limitations of this test, including error rates (false positives and false negatives). Genetic counseling before and after testing is recommended.

Discrimination Risks: Genetic information could be used as a basis of discrimination. To address concerns regarding possible health insurance and employment discrimination, some countries, U.S. states and the U.S. government have enacted laws to prohibit genetic discrimination in those circumstances. The laws may not protect against genetic discrimination in other circumstances, such as when applying for life insurance or long-term disability insurance. Talk to your healthcare provider or genetic counselor if you have concerns about genetic discrimination prior to testing.

Pregnancy Outcome Information: Collecting information on your pregnancy after testing is part of a laboratory's standard practice for quality purposes, and is required in several states. As such, Genesys or its designee may contact your healthcare provider to obtain this information.

Incidental Findings: In the course of performing the analysis for the indicated tests, information regarding other chromosomal alterations may become evident (called Incidental Findings). Our policy is to NOT REPORT on any Incidental Findings that may be noted in the course of analyzing the test data.

Privacy: We keep test results confidential. Your test results will only be released in connection with the testing service, to your healthcare provider, his or her designee, other healthcare providers involved in your medical care, or to another healthcare provider as directed by you (or a person legally authorized to act on your behalf) in writing, or otherwise as required or authorized by applicable law.

Use of the Information and Leftover Specimens: Pursuant to best practices and clinical laboratory standards leftover de-identified form specimens (unless prohibited by law) as well de-identified genetic and other information learned from your testing may be used by Genesys or others on its behalf for purposes of quality control, laboratory operations, laboratory test development, and laboratory improvement. All such uses will be in compliance with applicable law. Leftover specimens from New York State will be destroyed within 60 days.

Research: We may use your leftover specimen and your health information, including genetic information, in an anonymized or de-identified specimen (unless otherwise allowed by applicable law) for research purposes. Such uses may result in the development of commercial products and services. You will not receive notice of any specific uses and you will not receive any compensation for these uses. All such uses will be compliance with applicable law. This does not apply to leftover specimens collected from New York State.

Test Results: Your test results will be sent to the healthcare provider that ordered the test. Speak with him/her if you would like a copy of the test results. Your healthcare provider is responsible for interpreting the test results and explaining the meaning to you. Genesys does provide genetic counseling services directly to patients.