Integrated GENETICS
LabCorp Specialty Testing Group

10834750

PREGNANCY/PRECONCEPTION TEST REQUISITION

PLEASE SUBMIT A SEPARATE REQUISITION FOR EACH PATIENT, INCLUDING TWINS

Highlighted fields are required.

Patient Information

Name ______ Last ______ First ______ MI

☐ Male ☐ Female Date of Birth / /

Address

Home Phone Work Phone

Social Security Number

City State Zip

Lab # Hospital #

Client Information

Allina Health Laboratory
Abbott Northwestern Hospital
Referral Desk - Suite 2000
2800 10th Avenue South
Minneapolis MN 55407

Client #: 602685 602686

I attest that this patient has been informed about and has given consent for the test(s) I have ordered below under applicable law.

Physician/Authorized Signature:

NPI#: Taxonomy#:

Referring Physician (print):

Genetic Counselor (print):

Date drawn: / / Drawn by:

Pregnant: ☐ Yes ☐ No First pregnancy ☐ Yes ☐ No Date sent: / /

Specimen Type (Check one only):

Parental ☐ Peripheral Blood ☐ Mouthwash ☐ Blood spot card

Fetal ☐ Fetal Blood ☐ Amniotic Fluid ☐ Chorionic Villi ☐ POC

Back-up culture by: ☐ Integrated Genetics ☐ Other ______ Hold for: ______

Ethnicities (Check all that apply): ☐ Caucasian ☐ Ashkenazi Jewish ☐ Sephardic Jewish ☐ Asian ☐ African American ☐ Native American ☐ Hispanic ☐ Other:

Maternal Serum/Plasma Screening

550746 ☐ informaSeq℠ Prenatal Test (10w+) *
550757 ☐ informaSeq℠ with Y Analysis (10w+) *
550716 ☐ informaSeq℠ with X,Y Analysis (10w+) ***
315 ☐ FirstScreen®* (10w 3d – 13w 6d)
335 ☐ SequentialScreen℠*
302 ☐ IntegratedScreen℠*
302 ☐ Serum IntegratedScreen℠* (without NT measurement)
325 ☐ AFP4® (15w 0d – 21w 6d)
310 ☐ MSAFP (ONTD only; 15w 0d – 23w 6d)

*Professional associations recommend use in high risk pregnancy
**singleton pregnancy
*Dried blood spot samples acceptable for first trimester only.

Clinical Information for Maternal Serum/Plasma Screening

Gravida: Para: SAB: TAB: # Fetuses*: 1 ☐ 2 ☐ >2 ☐ Repeat Screen ☐

Sonographer Name: NTQR ID#:

Reading MD NTQR ID#: Practice Location ID#:

U/S date: / / GA on U/S date: wks days Maternal Weight lbs.

NT: mm CRL: mm For Twin: NT: mm CRL: mm

LMP date: / / EDC date: / / by ☐ U/S ☐ LMP ☐ PE ☐ IVF

IVF fertilization date**: / / IVF egg donor: ☐ Self ☐ Non-Self Donor Age:

Y ☐ N ☐ Patient is Rx-dependent diabetic prior to pregnancy (648.03, 250.00)
☐ insulin (V58.67) ☐ oral hypoglycemics (V58.69)

Y ☐ N ☐ Previous Down syndrome pregnancy/child (655.23)

Y ☐ N ☐ Family hx of NTD (655.23), specify: Relative (V18.9):

*Assume 1 if left blank
**Assume non IVF if left blank

Single Gene Disorders/Diseases

Ashkenazi Jewish Testing

(may be appropriate for other ethnicities)

☐ Check here for all Ashkenazi Jewish Carrier Tests or check separately

562 ☐ Bloom syndrome*
554 ☐ Canavan disease*
530 ☐ CFplus® (97 mutation test)†*
519 ☐ Dihydrolipoamide dehydrogenase deficiency*
207 ☐ Familial dysautonomia*
585 ☐ Familial hyperinsulinism*
534 ☐ Fanconi anemia (Group C)*
595 ☐ Gaucher disease*
522 ☐ Glycogen storage disease type 1a*
501 ☐ Joubert syndrome 2*
518 ☐ Maple syrup urine disease*
573 ☐ Mucolipidosis type IV*
587 ☐ Nemaline myopathy*
557 ☐ Niemann-Pick type A*
593 ☐ Tay-Sachs enzymes and DNA*
350 ☐ Tay-Sachs enzymes only
589 ☐ Usher syndrome type IF*
599 ☐ Usher syndrome type III*
502 ☐ Walker-Warburg syndrome*

Thrombophilia‡

549 ☐ Factor II (prothrombin G20210A)
548 ☐ Factor V (Leiden)
526 ☐ MTHFR (C677T)

Pan Ethnic Testing

☐ Check here for all Pan Ethnic Carrier Tests or check separately

530 ☐ CFplus® (97 mutation test)†*
523 ☐ Fragile X Carrier Screen (no fam hx)†
516 ☐ Spinal muscular atrophy (SMA)†*
Both parents bloods required for prenatal dx

540 ☐ Inheritest® Carrier Screen†
541 ☐ Inheritest® Select Carrier Screen†
☐ Check here for all tests listed below or order individually
516 ☐ Spinal muscular atrophy (SMA)†*
523 ☐ Fragile X Carrier Screen†
350 ☐ Tay-Sachs enzymes

☐ Mutation Specific Sequencing (call before sending)
Required: Gene(s): ______
Mutation(s): ______

Other Tests‡

521 ☐ Fragile X Test (symptomatic/fam hx)*
528 ☐ Maternal cell contamination*
538 ☐ Poly (T) Testing for CFTR Intron 8
535 ☐ Sickle cell anemia* (prenatal dx only)
593 ☐ Tay-Sachs DNA (prenatal dx only)*
591 ☐ Y chromosome microdeletions
Other test: ______

Hereditary Breast and Ovarian Cancer

(clinical questionnaire required, components on back)

☐ BRCAssure℠: Comprehensive Analysis
☐ BRCAssure℠: Ashkenazi Jewish Panel

*Maternal cell contamination analysis required for all prenatal dx (send a maternal sample).

Clinical Information/Single Gene Testing (‡If not checked, screening assumed (V82.89))

Parental: ☐ No family history (V82.89) ☐ Abnormal fetal U/S* (655.83) ☐ Family hx: relative* (655.23) ☐ Known carrier (655.23)* ☐ Thrombophilia* (286.9) ☐ Infertility (M: 606.9, F: 628.9 ☐ Egg donor (V59.70) ☐ Sperm donor: (V59.8) ☐ Congenital absence of vas deferens (752.89)

Fetal: ☐ Abnormal fetal U/S* (655.83) ☐ Family hx: relative* (655.23) ☐ Parent(s) known carrier(s)* (655.23)

*Provide additional information:

Cytogenetics/FISH/Biochem

100 ☐ Amniotic fluid chromosomes
300 ☐ AF-AFP†
330 ☐ Acetylcholinesterase (AChE)
110 ☐ CVS chromosomes
105 ☐ InSight® (FISH for 13, 18, 21, X, Y)
Other ______
287 ☐ DiGeorge/VCF (22q11.2 deletion)
☐ Other FISH: ______
123 ☐ Fetal blood (PUBS) chromosomes
180 ☐ POC chromosomes: GA week: ______
POC tissue type: ______
120 ☐ Blood Chromosomes (parental)

Clinical Information/Test Indications for Cytogenetics/FISH

Gravida: Para: SAB: TAB: # Fetuses: ☐ 1 ☐ 2 ☐ >2 Maternal Weight lbs.

U/S date: / / GA on U/S date: wks days LMP date: / / EDC date: / /

☐ AMA (para gravida: 659.53, multigravida: 659.63)
☐ Positive serum screen (655.83): ☐ NTD (655.03) ☐ Down syndrome (655.13) ☐ Trisomy 18 (655.13)
☐ Abnormal fetal U/S (655.83): ☐ CNS* (655.03) ☐ Other* (655.83)
☐ Family history of (655.23): ☐ NTD ☐ Chromosome abnormality* ☐ MR* ☐ Other*
☐ Parental cytogenetics following abnormal prenatal results* (F: 655.13, M; V26.39)
☐ Multiple Spontaneous abortions (SAB): ☐ F (Pregnant: 646.33, Not Pregnant: 629.81) ☐ M (V26.35)

*Provide additional information:

†Reflex policy: The following will be performed at additional charge: AChE when AF-AFP is elevated &/or GA is out of range of normative values; Fetal HGB when AF-AFP is elevated & amniotic fluid is bloody; CFTR Intron 8 poly(T) when R117H CF mutation is present; Southern blot analysis when Fragile X PCR shows >54 CGG repeats; SMN2 analysis when SMN1 indicates 0 copies.

BILLING INFORMATION

Patient Hospital Status: ☐ Inpatient ☐ Outpatient ☐ Non-hospital

☐ Medicaid ☐ Medicare ☐ Insurance ☐ Client Bill ☐ CA XAFP ☐ Self-Pay

☐ Billing Information Attached (Please include a copy of insurance card or face sheet.)

Do not attach credit card information to this form for security purposes.

Insurance Company Name ______

Policy # ______ Group # ______

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______

Patient Signature ______ Date: ______

INTEGRATED GENETICS INTERNAL USE ONLY

By signing this form, I hereby authorize Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to LCAH.

I understand that I am responsible for any amounts not paid by insurance for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.

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