labcorp

Testing will be performed at a Labcorp laboratory, including formerly branded Integrated Genetics.

For Accessioning
Labcorp PST send to:
3400 Computer Drive
Westborough, MA 01581

PREGNANCY/PRECONCEPTION TEST REQUISITION

PLEASE SUBMIT A SEPARATE REQUISITION FOR EACH PATIENT, INCLUDING TWINS

Highlighted fields are required.

Client Information / Patient Information

Name
Last First MI

☐ Male ☐ Female Date of Birth

Address

Phone Email

City State Zip

Lab # Hospital #

I have obtained informed consent of the patient (or the patient's authorized representative) for the ordered genetic test(s) in accordance with applicable law.

Physician/Authorized Signature:

Referring Physician (print):

Genetic Counselor (print):

NPI#: Taxonomy#:

Refer to womenshealth.labcorp.com to access informed consent forms for genetic testing.

Date drawn:

Drawn by:

Date sent:

Pregnant: ☐ Yes ☐ No First pregnancy ☐ Yes ☐ No Gravida: _____ Para: _____ SAB: _____ TAB: _____

Fetuses^: 1 ☐ 2 ☐ >2 ☐ Repeat Screen ☐ (^assume 1 if left blank) Fetal Sex, if known: ☐ Female ☐ Male ☐ Unknown by ☐ U/S ☐ NIPS ☐ PGT

U/S date: GA on U/S date: wks days; LMP date: EDC date: by ☐ UIS ☐ LMP ☐ PE ☐ IVF

IVF fertilization date^^: IVF egg donor: ☐ Self ☐ Non-Self Donor Age: (^^ assume non IVF if left blank)

Ethnicities: ☐ African American ☐ Ashkenazi Jewish ☐ Caucasian ☐ East Asian ☐ Finnish ☐ Hispanic ☐ Native American ☐ Sephardic Jewish ☐ South Asian ☐ Other:_____

Parental Testing

Specimen Type: ☐ Blood ☐ Saliva ☐ Buccal swab

481758 ☐ Inheritest® CF/SMA Panel
481776 ☐ Inheritest® Core Panel*
481797 ☐ Inheritest® 14-gene Panel*
481816 ☐ Inheritest® High Frequency Panel*
481855 ☐ Inheritest® 100 PLUS Panel*
481874 ☐ Inheritest® 300 PLUS Panel*
481893 ☐ Inheritest® 500 PLUS Panel*

*Males not tested for x-linked disorders

Partner's name: _____

Partner's DOB: _____

482595 ☐ Partner Reflex to GeneSeq (male partner only)

By providing the reproductive partner's information, you, the ordering provider, confirm that you have obtained from the patient and reproductive partner all required consents and/or authorizations necessary for the use and disclosure of protected health information, including test results, between the patient and reproductive partner. A separate requisition is required for each partner.

482370 ☐ GeneSeq PLUS ☐ VUS opt out
Gene(s): _____

482552 ☐ Targeted Variant Analysis (include report)
Gene: _____
Variant: _____

482632 ☐ Cystic Fibrosis (CF) Full-gene Carrier Screen
481025 ☐ Cystic Fibrosis (CF), 97 Variants
481684 ☐ Fragile X Syndrome, Carrier
481701 ☐ Fragile X Syndrome, Diagnostic
481630 ☐ Spinal Muscular Atrophy (SMA)
482109 ☐ Maternal Cell Contamination (MCC) with fetal molecular testing
511402 ☐ Maternal Cell Contamination (MCC) with fetal SNP

(Send 1 tube for each MCC request)

350 ☐ Tay-Sachs enzymes (blood only)
120 ☐ Chromosome analysis (blood only)

☐ Parental blood for _____
☐ Other testing: _____

Maternal Serum/Plasma Screening

Specimen Type: ☐ Blood ☐ Blood spot card

451927 ☐ MaterniT® 21 PLUS (9w+)
451931 ☐ MaterniT® 21 PLUS+ ESS (9w+)♦
451934 ☐ MaterniT® 21 PLUS+ SCA (9w+)†**
451937 ☐ MaterniT® 21 PLUS+ ESS + SCA (9w+)♦†**
451951 ☐ MaterniT® 21 PLUS No Gender (9w+)
451941 ☐ MaterniT® GENOME (9w+)**
315 ☐ FirstScreen®* (10w 3d - 13w 6d)
335 ☐ Sequential Screen℠*
302 ☐ Integrated Screen℠*
302 ☐ Serum Integrated Screen℠* (without NT measurement)
325 ☐ AFP4® (15w 0d - 21w 6d)
310 ☐ MSAFP (ONTO only; 15w 0d - 23w 6d)

452104 ☐ GENOME-Flex (Add On)**
452114 ☐ GENOME-Flex (Add On) Redraw**

♦ESS = chr 16, chr 22, and select microdeletions †SCA = sex chromosome aneuploidies
*Dried blood spot samples acceptable for first trimester only. **singletons only

Clinical information:

Sonographer Name: NTQR ID#:

Reading MD NTQR ID#: Practice Location ID#:

NT: mm CRL: mm Maternal weight: _____ lbs

For twin: NT: mm CRL: mm

Y ☐ N ☐ Patient is Rx-dependent diabetic prior to pregnancy ☐ Insulin/Oral hypoglycemics

Y ☐ N ☐ Previous pregnancy/child with Down syndrome

Y ☐ N ☐ Family hx of: ☐ NTD, specify: Relative:

Prenatal Diagnostic/ POC Testing

Specimen Type: ☐ CVS ☐ Amniotic Fluid ☐ POC
☐ Cordblood ☐ PUBS ☐ Cultured CVS ☐ Amniocytes
☐ Back-up culture held by client

☐ InSight® (FISH for 13, 18, 21, X, Y)
☐ Reflex to SNP if InSight® normal or reflex to chromosome if InSight® abnormal
☐ Chromosome Analysis
☐ Reflex to SNP if chromosomes normal
☐ Reflex to SNP if POC chromosomes fail to grow
☐ Reveal® SNP Microarray (GA required) ☐ Add MCC to SNP
☐ Hold cells for _____
287 ☐ FISH DiGeorge/VCF (22q11.2 deletion)
300 ☐ AF-AFP **330** ☐ ACHE

Maternal blood for MCC required with fetal molecular testing
481573 ☐ Cystic Fibrosis, 97 Variants, Fetal Analysis
481718 ☐ Fragile X Syndrome, Fetal Analysis
482299 ☐ Noonan Syndrome, Fetal Analysis
482091 ☐ Sickle Cell, Fetal Analysis
481651 ☐ Spinal Muscular Atrophy (SMA), Fetal Analysis
482389 ☐ GeneSeq PLUS, Fetal Analysis ☐ VUS opt out
Gene(s): _____
482534 ☐ Targeted Variant Analysis, Fetal Analysis (include report)
Gene: _____ Variant: _____
☐ Other testing: _____

Clinical indication (parental): If not checked, screening assumed

☐ No family history/Screening
☐ Known carrier ☐ Partner is a carrier
Disorder/Gene: _____
☐ Multiple SAB
☐ Family history (provide additional information)
☐ Chromosome abnormality (include report):
☐ Other:

Clinical indication (maternal serum screening/prenatal diagnostic testing):

☐ AMA ☐ Abnormal serum screen: ☐ T21 ☐ T18 ☐ NTD ☐ _____
☐ Abnormal NIPS (include report): ☐ T21 ☐ T18 ☐ _____
☐ Abnormal fetal ultrasound (must specify): ☐ Increased NT ☐ Cystic hygroma
☐ IUGR ☐ Heart defect (specify) _____
Other (specify): _____
Disorder: Relative:

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; **methylation PCR analysis** when Fragile X PCR result is >54 CGG repeats; **SMN2 analysis** when SMN1 result is 0 copies.

All diagnoses should be provided by the ordering physician or an authorized designee. Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required)

ICD-CM		ICD-CM		ICD-CM	

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: _____

LABCORP 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.

* For SNP Microarray, if DNA is sent, the lab only accepts isolated or extracted nucleic acid for which extraction or isolation is performed in an appropriately qualified CLIA or CAP/CMS equivalent laboratory