Requisition Form – Prenatal Diagnosis

CombiMatrix

Client Information

Referring Physician _____ NPI _____

Ordering Physician _____ NPI _____

Genetic Counselor/Clinical Contact _____

Tel _____ Fax _____

Email _____

Authorized Signature _____

Patient Information

Last Name _____ First Name_____

DOB _____ Gender _____

Street Address _____

City, State Zip_____

Tel _____

Email _____

Medical Record Number_____

Billing Information

Bill: ❑ Institution ❑ Insurance ❑ Medicare ❑ Medicaid ❑ Patient

Insurance Information ❑ See attached

Insured Information Name _____

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other:_____

Primary Insurance Co._____ Authorization #_____

Billing Address _____ Insured #_____

Billing City, State, Zip_____ Group #_____

Secondary Insurance Co. _____ Authorization #_____

Billing Address _____ Insured #_____

Billing City, State, Zip _____ Group #_____

For Patient Bill cases, complete and submit "Self-Pay Testing Option" form. Testing will not be performed unless a completed form is received.

Patient Authorization/Assignment
I authorize CombiMatrix to obtain and release relevant medical and other information as needed to submit claims to Medicaid, Medicare, or Medicare Supplemental for laboratory services CombiMatrix provides to me. I assign insurance benefits to CombiMatrix and acknowledge that charges not covered by my insurance, including any applicable copayments or deductibles, are my responsibility, and I agree to pay them.

_____
Print Name of Patient or Guardian

_____
Signature of Patient or Guardian Date (mm/dd/yyyy)

Prenatal Testing

Collection Date _____ # Tubes _____

Specimen ID #(s) _____

Sample Type

❑ Chorionic villi ❑ Amniotic fluid ❑ Parental blood ❑ Other: _____
❑ Cultured CVS ❑ Cultured amniocytes ❑ DNA Source: _____

Pregnancy History

Gestational age: _____ wks _____ days by ❑ LMP ❑ U/S

Gravida _____ Para _____ SAB _____ TAB _____

Is the pregnancy currently ongoing? ❑ Yes ❑ No, SAB/IUFD ❑ No, TAB

How many fetuses? ❑ 1 ❑ 2 ❑ 3

Fetal gender: ❑ Female ❑ Male ❑ Unknown

Fetal karyotype: ❑ 46,XX ❑ 46,XY ❑ Not performed ❑ Pending ❑ Abnormal*

NIPT results: ❑ Not performed ❑ Normal ❑ Abnormal*

** * * If fetal karyotype and/or NIPT results are ABNORMAL, please enclose a copy of the report(s) * * **

Prenatal Indications

❑ Advanced maternal age: ○ primagravida (009.519) ○ multigravida (009.529)

❑ Abnormal maternal serum screening/NIPT suggestive of a fetal chromosomal abnormality (O28.5)

❑ Abnormal maternal serum screening suggestive of a neural tube defect (O28.1)

❑ Other abnormal findings on antenatal screening of mother (O28.8)

❑ Abnormal fetal ultrasound (O28.3); Specify abnormality: _____

** * * Please indicate abnormalities on the Phenotypic Checklist provided with the CombiMatrix Kits * * **

❑ Other _____ ICD-10 _____

Prenatal Testing Options – CVS and Amniocentesis

❑ Amniotic fluid AFP with reflex to AChE (amniocentesis only)

❑ CombiFISH™ (interphase FISH for 13, 18, 21, X, Y)
(must order karyotype or microarray in addition to CombiFISH for confirmation)

❑ CombiSNP™ microarray analysis
○ CombiSNP™ Whole Genome Array (with confirmation FISH when indicated)
○ CombiSNP™ Targeted Prenatal Array (with confirmation FISH when indicated)
Reflex to karyotype if microarray is normal? ❑ Yes ❑ No

❑ Karyotype
Reflex to microarray (on cultured cells) if karyotype is normal? ❑ Yes ❑ No
○ CombiSNP™ Whole Genome Array (with confirmation FISH when indicated)
○ CombiSNP™ Targeted Prenatal Array (with confirmation FISH when indicated)

Parental/ Familial Studies

For parental or family studies, please complete the Parental and Family Studies Test Requisition form. You can access this and other forms on our website at: www.combimatrix.com/providers/forms.

Special Instructions/Additional Testing Requests

For any testing requests not listed on this form, please contact one of our Genetic Counselors at 949.255.0921 to arrange testing. Please note that that most reference laboratories require proper supporting documentation of the specific familial mutation, as well as a maternal blood sample to test for maternal cell contamination.