

## 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

Gravida \_\_\_\_\_ Para \_\_\_\_\_ SAB \_\_\_\_\_ TAB \_\_\_\_\_  
 Is the pregnancy currently ongoing?  Yes  No, SAB/IUFD  No, TAB  
 How many fetuses?  1  2  3 Gestational age: \_\_\_\_ wks \_\_\_\_ days by  LMP  U/S  
 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:  primigravida (009.519)  multigravida (009.529)  
 Abnormal maternal serum screening/NIPT suggestive of a fetal chromosomal abnormality (028.5)  
 Abnormal maternal serum screening suggestive of a neural tube defect (028.1)  
 Other abnormal findings on antenatal screening of mother (028.8)  
 Abnormal fetal ultrasound (028.3); 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](http://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 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.