

**CLIENT INFORMATION**
**PATIENT INFORMATION**

Name: LAST FIRST MI

Address

City State Zip

Date of Birth Patient Sex:  Male  Female

Home Phone Number Patient Social Security

Work Phone Number Patient ID#

ICD-9 CODE (Required)

**BILLING / INSURANCE**
**PHOTOCOPY BOTH SIDES OF INSURANCE CARD & ATTACH**

Bill Client  Bill Patient  Primary Insurance  Secondary Insurance  Other

Medical Group  HMO  PPO  Hospital  Medicaid (Copy of Card Required)

Medicare (Copy of Card Required) Medicare patients MUST REVIEW and SIGN the Advanced Beneficiary Notice for non-covered services.

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Ins. Company Name: \_\_\_\_\_

Claim Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Claim Phone: \_\_\_\_\_ Employer #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ D.O.B.: M / D / Y

**BILLING / SELF PAY**

Payment Info:  Self Pay  Payment Enclosed Amount: \$ \_\_\_\_\_

Credit Card:  Master Card  Visa  Amex  Discover

Card #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Card Holder Name: \_\_\_\_\_

Card PVS #: \_\_\_\_\_ (usually 3 or 4 digits on back of card)

Card Billing Address: \_\_\_\_\_

Card holder Signature: \_\_\_\_\_

**CLINICAL INFORMATION - Mark All That Apply**

Date of Collection: M / D / Y Last Menstrual Period: M / D / Y

Ethnic Background:  Caucasian  African-American  Asian

Hispanic  Ashkenazi Jewish  Other: \_\_\_\_\_

Patient Weight: \_\_\_\_\_ lbs.  G  P

Insulin Dependent Diabetes  Vaginal Bleeding with this Pregnancy

Is/Was Patient a Smoker - If Yes, Indicate Date Quit: M / D / Y

IVF Pregnancy  EGG Donor (Age at Retrieval): \_\_\_\_\_

Previous Pregnancy History of:  ONTD  Down Syndrome

Genetic Disorders  Other: \_\_\_\_\_ (Attach Pedigree if Available)

**ULTRASOUND INFORMATION**

Date of CRL: M / D / Y CRL: \_\_\_\_\_ mm (Valid range from 41 - 79 mm)

GA at time of CRL Ultrasound: \_\_\_\_\_ Weeks \_\_\_\_\_ Days

Date of NT Ultrasound: (if different than CRL US) M / D / Y NT: \_\_\_\_\_ mm

GA at time of NT Ultrasound: \_\_\_\_\_ Weeks \_\_\_\_\_ Days

NT Sonographer: \_\_\_\_\_ NTQR#: \_\_\_\_\_ FMF#: \_\_\_\_\_

US Reviewer of NT (MD/DO): \_\_\_\_\_ NTQR#: \_\_\_\_\_ FMF#: \_\_\_\_\_

If  Multiple Births - # of Fetuses: \_\_\_\_\_ if Twins ( \_\_\_\_\_ Dichorionic \_\_\_\_\_ Monochorionic)

2nd CRL (if Twins): \_\_\_\_\_ mm | 2nd NT (if Twins): \_\_\_\_\_ mm

**INDICATIONS FOR TESTING**

Routine Aneuploidy Screening of Low Risk Patient Screening

Abnormal Antenatal Screening for: \_\_\_\_\_

Fetal Ultrasound Finding(s): \_\_\_\_\_

Clinical Suspicion of Disease: \_\_\_\_\_

Carrier Screening Analysis (No Family History)  Family History: \_\_\_\_\_

Other: \_\_\_\_\_

**INFORMED CONSENT FOR RISK ASSESSMENT / GENETIC TESTING**

I have received information regarding the nature of the test(s) noted, either from my healthcare provider or on the back of this form and hereby give my consent to perform the test(s) and further consent that my blood, amniotic fluid and/or urine shall be property of LENETIX<sup>®</sup>, that you may contact me for outcome information and authorize payments of medical benefits to LENETIX<sup>®</sup> for services described.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I decline any of the above tests offered to me and understand the consequences of my decision.

Patient DECLINE: Signature \_\_\_\_\_ Date: \_\_\_\_\_

\* Your second blood sample should be drawn between \_\_\_\_\_ and \_\_\_\_\_ Date Drawn: M / D / Y

Treating Physician: \_\_\_\_\_ UPIN#: \_\_\_\_\_

I have reviewed the back of this form and authorize the testing of this specimen for test(s) noted. If the results are abnormal, follow-up will be recommended by the diagnostic center at: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: M / D / Y

Send Duplicate of Report to: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_ EMAIL: \_\_\_\_\_

**LABORATORY TESTS ORDERED**
**MATERNAL RISK ASSESSMENT**
**FIRST & SECOND TRIMESTER**

Integrated 190\* (includes NT)  Serum Integrated 270\* (no NT)

3327  Stage 1: PAPP-A (11 weeks - 13 weeks 6 days)

3325  Stage 2: AFP, total  $\beta$ hCG, uE3, inhibin A (15 weeks - 22 weeks 6 days)

Modified Sequential 30•190\* (includes NT)  Contingent 30•1500•190\* (includes NT)

1414  Stage 1: PAPP-A, total  $\beta$ hCG (11 weeks - 13 weeks 6 days)

3325  Stage 2: AFP, total  $\beta$ hCG, uE3, inhibin A (15 weeks - 22 weeks 6 days)

**FIRST TRIMESTER - (11 weeks - 13 weeks 6 days)**

1414  Combined (total  $\beta$ hCG, PAPP-A) (includes NT)

1414A  Combined Plus (total  $\beta$ hCG, PAPP-A, inhibin A) (includes NT)

**SECOND TRIMESTER - (15 weeks - 22 weeks 6 days)**

3121  Quad Screen (AFP, total  $\beta$ hCG, uE3, inhibin A)

608  AFP (ONTD Only)

**MOLECULAR GENETIC TESTS**

3417  Ashkenazi Jewish Carrier 9 Risk 738  Fanconi Anemia (Group C)

Assessment: [Bloom Syndrome, Canavan 2006  Fragile X Syndrome

Disease, Cystic Fibrosis, Familial Dysautonomia, 1509  Gaucher Disease

Fanconi Anemia (Group C), Gaucher Disease, 318  Glycogen Storage (Type 1A)

Niemann-Pick Disease (Type A and Type B), 319  Maple Syrup Urine Disease

Mucopolipidosis (Type IV), and Tay-Sachs (DNA) 6410  Mucopolipidosis (Type IV)

1278  Bloom Syndrome 3127  Niemann-Pick Disease (Type A & B)

1508  Canavan Disease 243  Sickle Cell Anemia

1800  CF (5T-Allele) 2362  Spinal Muscular Atrophy (SMA)

1341  Cystic Fibrosis 2312  SRY, X & Y

3135  Familial Dysautonomia 558  Tay-Sachs DNA (Reflex)

1788  Familial Hyperinsulinism 2313  Y Chromosome Microdeletion

1118  RhD & SRY Genotyping (must be drawn after 15 weeks gestational age)  Other \_\_\_\_\_

**CYTOGENETICS**

1655, 3108  Amniotic Fluid Chromosome Analysis (Includes Amniotic Fluid AFP)

1118  Chorionic Villus Sampling (CVS)

3110  Amniotic Fluid RHD

1116  POC/Other Tissue, Specify: \_\_\_\_\_

1094  AneuVysion<sup>®</sup> FISH (Chromosomes 13,18,21,X,Y)

684  Peripheral Blood Chromosome Analysis

Other: \_\_\_\_\_

**OTHER BIOCHEMICAL TESTS**

3109  Amniotic Fluid AFP 0505  Inhibin A and B

556  Tay-Sachs (Enzyme) 82103  Acetylcholinesterase (AChE)

1052  Fetal Fibronectin

**REFLEX POLICY:** AChE and HbF are run in cases of elevated AFAP (greater than 2.0 MOM). CFTR Intron 8 poly(T) is run in cases of R117H.

