Variantyx

IriSight™ Comprehensive Analysis - Pregnancy Loss
Test Requisition Form
Page 1 of 2

Patient Name (fetus of)	
Patient Date of Birth	

Affix barcode label of fetal sample here

- ❍ Pregnancy and parent demographics
- ❍ ICD-10 codes
- ❍ Healthcare provider signature
- ❍ Signed informed consents
- ❍ Ultrasound report(s), if available
- ❍ Pathology and/or Autopsy records, if available
- ❍ Delivery notes (including RN and Physician notes)
- ❍ **Completed TRF and all clinical notes faxed to 508-302-8022**
- ❍ Clinical & genetic counseling notes with pedigree (please include all family history of known chronic and inherited disease and copies of genetic test results if available)

Test Order

◯ IriSight™ CNV Analysis (RPG002)	◯ Duo (For MCC) ◯ Trio
◯ Opt-In Variants of Uncertain Significance (for trios with clinical indication only)	*No selection will default to an opt-out option. Variants of uncertain significance (VUS) may be reported if correlated with the provided clinical symptoms of the fetus, the pregnancy and/or the family history. Additionally, VUS will only be reported for trios. For more information see test information.*
◯ If the IriSight™ CNV Analysis does not yield in a diagnostic result reflex to IriSight™ Comprehensive Analysis - Pregnancy Loss (RPG100) **Reflex to RPG100 might not be covered by insurance.*	
◯ IriSight™ Comprehensive Analysis - Pregnancy Loss (RPG100)	◯ Duo (For MCC) ◯ Trio
◯ Opt-In Variants of Uncertain Significance (for trios only)	*No selection will default to an opt-out option. Variants of uncertain significance (VUS) may be reported if correlated with the provided clinical symptoms of the fetus, the pregnancy and/or the family history. Additionally, VUS will only be reported for trios. For more information see test information.*
◯ Opt-In ACMG Secondary Findings	*No selection will default to an opt-out option and findings in this category will not be returned. For more information see test information*

Ordering Healthcare Provider

First Name	Last Name	Title	NPI #
Facility Name			Phone
Facility Address			Fax
City	State	Zip Code / Country	Email

Additional Report Recipients

Full Name	Phone	Fax	Email
Full Name	Phone	Fax	Email

Billing Information

ICD-10 Code(s)* **ICD-10 codes must be specified here and/or in attached clinical notes*	Suspected Diagnosis

◯ Insurance Billing

Insurance Company	Policy #	Group #
Policy Holder First Name / Policy Holder Last Name		Policy Holder DOB
Who is the Policy Holder? ◯ Patient ◯ Spouse ◯ Parent	Policy Holder's Employer	Employer's Address

◯ Institutional Billing

An invoice will be sent to institution listed above. Contact us for alternate billing.
Billing Contact Name:
Billing Contact Email:

◯ Patient Payment *Who should be contacted for billing purposes?*

Payer Name:
Payer Email:
Payer Phone:
An invoice will be sent to the patient email provided. Insurance will not be billed.

Healthcare Provider's Statement

By my signature below, I attest that I am the referring physician, an authorized healthcare provider for the patient, or procurator thereof and this testing is medically necessary for diagnosis and/or treatment of the fetus. I attest that the guardian(s) have been appropriately consented to the test including possible results and outcomes, including variants of uncertain clinical significance (VUSs) and ACMG secondary findings, if selected, and have been given the opportunity to ask questions about the testing and/or seek genetic counseling. I agree to allow an independent genetic counselor facilitated through a third party to provide pre-test and/or post-test genetic counseling, if required by the insurer and/or referring institution. I attest that the guardian(s) have voluntarily consented to testing performed by Variantyx for diagnostic purposes through both oral and written consent.

Healthcare provider signature _____ Date _____

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IriSight™ Comprehensive Analysis - Pregnancy Loss
Test Requisition Form

Patient Name (fetus of)	
Patient Date of Birth	

Affix barcode label of fetal sample here

Pregnant Patient Information

First Name	Last Name	MI	DOB
Address			ID/MR#
City	State	Country	Zip Code
Phone	Email		
Sample Type ◯ Blood ◯ Other:	Sample Collection Date	Sample will be collected ◯ In-House ◯ By Variantyx	

Biological Maternal Information (if egg donor or gestational carrier)

First Name	Last Name	MI	DOB
Sample Type ◯ Blood ◯ Other:	Sample Collection Date	Sample will be collected ◯ In-House ◯ By Variantyx	

Biological Paternal Information

First Name	Last Name	MI	DOB
Sample Type ◯ Blood ◯ Other:	Sample Collection Date	Sample will be collected ◯ In-House ◯ By Variantyx	

Pregnancy History - Please attach detailed clinical notes (with pedigree if available)

G _____ P _____ A _____

Fetal Sample Type
◯ Products of Conception ◯ Tissue - Specify Origin _____ ◯ Cultured cells ◯ Genomic DNA

Collection Date*

Gestational Age at Collection
W _____ D _____

Expected Delivery Date

Predicted Fetal Sex
◯ Male ◯ Female ◯ Unknown ◯ Ambiguous

Multiple Pregnancy?
◯ Twin ◯ Triplet ◯ Other _____

Sperm Donation?
◯ Yes ◯ No

Egg Donation?
◯ Yes ◯ No

Abnormal Findings in Previous Pregnancies

Testing Previously Performed in Current Pregnancy

◯ FISH ◯ Karyotype ◯ Microarray ◯ Maternal Serum Screening ◯ Non-Invasive Prenatal Screening ◯ Other _____

Results:

Additional Notes:

*Note that the collection date is not the same as the date of service for test billing purposes. For more information, please see CMS guidelines.

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IriSight™ Comprehensive Analysis - Pregnancy Loss Supplement Form

Patient Name (fetus of)	
Patient Date of Birth	

Affix barcode label of fetal sample here

Fetus Phenotypes

		Phenotype
Growth	○	Cystic hygroma
	○	Hydrops fetalis
	○	Increased nuchal translucency
	○	Intrauterine growth restriction (IUGR)
	○	Large for gestational age (Macrosomia)
	○	Oligohydramnios
	○	Placental abnormality
	○	Polyhydramnios
	○	Single umbilical artery
	○	Other:
Neurological	○	Abnormal posterior cranial fossa morphology
	○	Anencephaly
	○	Aplasia/hypoplasia of the corpus callosum
	○	Cerebellar hypoplasia
	○	Choroid plexus cysts
	○	Dandy-Walker malformation
	○	Decreased fetal movement
	○	Holoprosencephaly
	○	Hydrocephalus
	○	Lissencephaly
	○	Spina bifida
	○	Ventriculomegaly
	○	Other:
Craniofacial	○	Cleft lip
	○	Cleft palate
	○	Hypertelorism
	○	Hypotelorism
	○	Macrocephaly
	○	Microcephaly
	○	Micrognathia
	○	Pierre-Robin sequence
	○	Other:
Pulmonary	○	Abnormality of the thoracic cavity
	○	Congenital cystic adenomatoid malformation of lung (CCAM)
	○	Congenital diaphragmatic hernia
	○	Diaphragmatic eventration
	○	Pleural effusion
	○	Other:
Gastrointestinal	○	Abnormal stomach morphology
	○	Choanal atresia
	○	Duodenal atresia
	○	Echogenic fetal bowel
	○	Gastroschisis
	○	Omphalocele
	○	Tracheoesophageal fistula
	○	Other:

		Phenotype
Cardiac	○	Aortic valve atresia
	○	Atrial septal defect (ASD)
	○	Atrioventricular canal defect
	○	Coarctation of aorta
	○	Dextrocardia
	○	Ebstein anomaly
	○	Echogenic intracardiac focus
	○	Hypoplastic left heart
	○	Hypoplastic right heart
	○	Pericardial effusion
	○	Pulmonary valve atresia
	○	Tetralogy of Fallot
	○	Transposition of the great arteries
	○	Truncus arteriosus
	○	Ventricular septal defect (VSD)
	○	Other:
Genitourinary	○	Ambiguous genitalia
	○	Fetal pyelectasis
	○	Hydronephrosis
	○	Hypogonadism
	○	Hypospadias
	○	Megacystis
	○	Polycystic kidneys
	○	Renal agenesis
	○	Urethral obstruction
	○	Other:
Musculoskeletal	○	Abnormal vertebral morphology
	○	Abnormality of the lower limb
	○	Abnormality of the upper limb
	○	Arthrogryposis multiplex congenita
	○	Contractures
	○	Clubfoot
	○	Polydactyly
	○	Rocker bottom foot
	○	Scoliosis
	○	Short long bone
	○	Skeletal dysplasia
	○	Syndactyly
	○	Other:

Other

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Website: www.variantyx.com | **Document number:** VYX-1001-0524