Variantyx IriSight® Comprehensive Analyses Test Requisition Form

Patient Name | Date of Birth | Affix barcode label of Patient's sample here

Required Information Checklist:

- ❍ Patient demographics
- ❍ ICD-10 codes
- ❍ Healthcare provider signature
- ❍ Signed informed consents
- ❍ Clinical & genetic counseling notes with pedigree; please include all family history of known chronic and inherited diseases and copies of genetic test results if available
- ❍ Completed TRF and all clinical notes faxed to 508-302-0528
- ❍ Letter of medical necessity and/or required insurance forms if applicable

Missing or insufficient information will cause a delay in pre-authorization and results*

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.*

❍ Opt-In Fluorescent In-Situ Hybridization (FISH) *No selection will default to an opt-out option. Rapid FISH is available for direct amnio/CVS and includes analysis for the common aneuploidies (13, 18, 21, X and Y). For more information see test information.*

❍ If the IriSight® CNV Analysis does not yield in a diagnostic result reflex to IriSight® Comprehensive Analysis - Prenatal (RPG001) **Reflex to RPG001 might not be covered by insurance.*

Irisight® Comprehensive Analysis - Prenatal (RPG001) ❍ Duo (For MCC) ❍ Trio

❍ 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.*

❍ 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.*

❍ Opt-In Fluorescent In-Situ Hybridization (FISH) *No selection will default to an opt-out option. Rapid FISH is available for direct/cultured amnio/CVS and cord blood and includes analysis for the common aneuploidies (13, 18, 21, X and Y). For more information see test information.*

Ordering Healthcare Provider

First Name	Last Name	Phone	# NPI

Facility Name	Facility Address

City	Zip Code	Email	Fax

Additional Report Recipients

Name	Phone	Fax	Email
Name	Phone	Fax	Email

Add GC or other healthcare provider(s)?

Billing Information

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

❍ 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

Address	Employer's Address

❍ Institutional billing

An invoice will be sent to the institution listed above. Please contact us for alternate billing.

❍ Patient Payment An invoice will be sent to the patient email provided. Insurance will not be billed.

Who should be contacted for billing purposes?

Payer Name: Payer Phone: Payer Email:

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 patient. I attest that the patient or guardian has voluntarily consented to genetic testing for diagnostic purposes, including possible results and outcomes, ACMG secondary findings, and pharmacogenomics analysis, if selected, has been given the opportunity to ask questions about the testing and/or seek genetic counseling, and agrees 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.

Healthcare provider signature _____ Date _____

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Patient Name | Date of Birth | Affix barcode label of Patient's sample here

Pregnant Patient Information

First Name	Last Name	MI	DOB
Address		#ID / MR	
City	State	Zip Code	Phone	Email
Sample Type ❍ Blood ❍ Other	Sample Collection Date	Sample will be collected ❍ In-Clinic ❍ By Variantyx ❍ Patient Given Kit	

Biological Maternal Information (if egg donor or gestational carrier was used)

First Name	Last Name	MI	DOB
Sample Type ❍ Blood ❍ Other	Sample Collection Date	Sample will be collected ❍ In-Clinic ❍ By Variantyx ❍ Patient Given Kit	

Biological Paternal Information

First Name	Last Name	MI	DOB
Sample Type ❍ Blood ❍ Other	Sample Collection Date	Sample will be collected ❍ In-Clinic ❍ By Variantyx ❍ Patient Given Kit	

Pregnancy History

G: P: A:	Sample Collection Date

Sample Type

❍ Direct amniotic fluid ❍ Fetal/cord blood ❍ Products of Conception ❍ Direct chorionic villus sampling (CVS)

❍ Cultured cells: Source: _____ ❍ Genomic DNA; Source: _____ ❍ Tissue - Specify Origin: _____

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
Backup Culture Kept at Another Lab? ❍ Yes ❍ No	If yes, where is the backup culture maintained? _____	

Abnormal Findings in Previous Pregnancies

Testing Previously Performed in Current Pregnancy

❍ FISH ❍ Karyotype ❍ Microarray ❍ Maternal Serum Screening

❍ Non-invasive Prenatal Screening ❍ Other _____

Results: