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Clinical Questionnaire for Inheritest[®] Carrier Screen and GeneSeq[®] PLUS

Prior authorization questions, call **866-248-1265**. / Fax **336-436-1007** / Test questions, call **800-848-4436**.

Email: **PriorAuthEscalations@Labcorp.com**

Name and title of person completing this form _____

Patient Information

First Name: _____ Last Name: _____ Date of Birth: _____

Indication for Testing and Relevant Patient/Partner History (to be completed by the provider)

- Select at least one:**
- Genetic counseling performed by board-certified genetic counselor or clinical geneticist. If marked, attach genetic counseling report.
 - Pretest counseling performed by ordering provider or designee in accordance with health plan policies.

- Patient Ethnicity:**
- African American
 - Ashkenazi Jewish
 - Asian American
 - Caucasian
 - Hispanic
 - Jewish, non-Ashkenazi
 - Other (specify) _____

Mark All That Apply

- Patient/partner is currently pregnant or is considering a pregnancy. If pregnant, specify gestational age: _____ weeks _____ days
- Patient had previous carrier screening. If marked, are screening results available? Yes No
- Patient has unknown or limited family history (e.g. adopted). Please specify: _____
- Patient has no known or suspected family history of CF, SMA, or fragile X
- Patient is a known carrier of the fragile X premutation, intermediate, or full mutation
- Partner has known diagnosis of congenital absence of the vas deferens
- Patient and partner are consanguineous (related by blood)
- Partner has a diagnosis of CF or SMA. Please specify: _____
- Biological relative has diagnosis of CF, SMA, or fragile X. Specify disease and relationship of the individual to the patient (e.g. brother, sister, niece, first cousin, second cousin, etc): _____
- Partner of a known mutation carrier. Please specify genetic disorder and mutation: _____
- Biological relative is a known mutation carrier. Specify mutation and relationship of the individual to the patient (e.g. brother, sister, niece, first cousin, second cousin, etc): _____
- Are testing results available? Yes No
- History of unexplained intellectual disability or developmental delay, or autism in the patient or a blood relative
- Personal history of premature ovarian insufficiency or failure, premature menopause, or infertility associated with elevated FSH levels before the age of 40 with no known cause
- Family history of fragile X syndrome, fragile X-associated primary ovarian insufficiency, or fragile X-associated tremor/ataxia syndrome
- History of late onset intention tremor and cerebellar ataxia of unknown origin

Ordering provider understands by signing below:

Pretest counseling, which includes an interpretation of family and medical histories; education about inheritance, genetic testing, disease management, prevention, and resources; counseling to promote informed choices and adaptation to the risk or presence of a genetic condition; and counseling for the psychological aspects of genetic testing, has been completed where required by health plan. Post-test counseling will be available.

Ordering Provider Signature

Date

Patient understands by signing below:

Labcorp may use information obtained on this form and other information provided by me and/or my ordering provider or his/her designee to initiate prior authorization with my health plan as required. I understand a prior authorization approval from my health plan does not guarantee full payment. It is my responsibility to contact my health plan regarding concerns over my coverage and benefits.

Patient Signature

Date

This is not an order for a test.

Please include this form with sample and order for testing.

