I have obtained informed consent of the patient (or the patient’s authorized representative) for the ordered genetic test(s) in accordance with applicable law.

Physician/Authorized Signature: ____________________________

NPI#: ____________________________  Taxonomy#: ____________________________

Collection date: / /  Date sent: / /  Collected by: ____________________________

Specimen Type (Check one specimen type.)

☐ Peripheral Blood
☐ POC/Fetal Tissue (GA wks _______ tissue origin _______ fetal sex if known _______)
☐ Skin biopsy
☐ Cord Blood
☐ Blood Spot Card
☐ Mouthwash
☐ Buccal swab

Laboratory Test(s) Ordered

See back □ Chromosome Analysis
See back □ FISH

☐ Prader-Willi
☐ Williams
☐ Miller-Dieker
☐ Kallmann
☐ DiGeorge/VCF
☐ Fragile X, PCR & Southern
☐ DEB Breakage Study (routine chromosome analysis included)
☐ Poly(T) Testing for CFTR Intron 8
☐ Autism/Autism spectrum disorders
☐ Developmental delay
☐ Other

☐ CGH
☐ CGH Plus
☐ CGH Plus

☐ Smith-Magenis
☐ Steroid Sulfatase Deficiency
☐ Williams
☐ Wolf-Hirschhorn

□ to access informed consent forms for genetic testing.

Indication(s) for Test (check all that apply)

☐ All diagnoses should be provided by the ordering physician or an authorized designee.

☐ Refer to www.integratedgenetics.com to access informed consent forms for genetic testing.

Refer to Genetic Counselor (print):

□ Autism/Autism spectrum disorders
□ Intellectual disability (ID)

□ Mild
□ Moderate
□ Severe
□ Profound

□ Parental chromosome analysis following abnormal postnatal results

☐ Other

☐ Clinical features of chromosome abnormality – specify

☐ Other infertility

☐ Identification of complete or partial mole (POC)

☐ Other

☐ Other

☐ Other

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