Integrated GENETICS
LabCorp Specialty Testing Group

PREGNANCY/PRECONCEPTION TEST REQUISITION

PLEASE SUBMIT A SEPARATE REQUISITION FOR EACH PATIENT, INCLUDING TWINS

Highlighted fields are required.

Patient Information

Name
Last First MI

☐ Male ☐ Female Date of Birth / /

Address

Home Phone Work Phone

City State Zip

Lab # Hospital #

Client Information

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:

Referring Physician (print):

Genetic Counselor (print):

NPI#: Taxonomy#:

Refer to womenshealth.labcorp.com to access informed consent forms for genetic testing.

Date drawn: / / Drawn by:

Pregnant: ☐ Yes ☐ No First pregnancy ☐ Yes ☐ No Date sent: / /

Specimen Type (Check one only):

Parental ☐ Peripheral Blood ☐ Mouthwash ☐ Blood spot card

Fetal ☐ Fetal Blood ☐ Amniotic Fluid ☐ Chorionic Villi ☐ POC

Back-up culture by: ☐ Integrated Genetics ☐ Other _____ ☐ Hold cells for:_____

Ethnicities (Check all that apply):

☐ Caucasian ☐ Ashkenazi Jewish ☐ Sephardic Jewish ☐ Asian ☐ African American ☐ Native American ☐ Hispanic ☐ Other:_____

Inheritest® Carrier Screen‡

630049 ☐ 500 PLUS Panel (more than 500 genes)◊∞

451950 ☐ Comprehensive Panel (144 genes)*†

451960 ☐ Society-guided Panel (14 genes)*†

451920 ☐ Ashkenazi Jewish Panel (48 genes)*†

451964 ☐ Core Panel (CF97, SMA, FraX)†

452172 ☐ CF/SMA Panel†

451910 ☐ Inheritest® Gene-specific Sequencing**

630068 ☐ GeneSeq PLUS (sequencing with del/dup & VUS)∞

630085 ☐ GeneSeq PLUS without VUS (sequencing with del/dup, without VUS)∞

Required gene(s): _____

640 ☐ Mutation-specific Sequencing**

Required gene(s): _____

Mutation(s): _____

Other Tests

530 ☐ CFplus® (97-mutation test)**‡

523 ☐ Fragile X, PCR Rflx Southern†‡

521 ☐ Fragile X, PCR & Southern**‡#

528 ☐ Maternal cell contamination

516 ☐ Spinal Muscular Atrophy**†‡

593 ☐ Tay-Sachs enzymes and DNA

350 ☐ Tay-Sachs enzymes only

451890 ☐ Noonan syndrome - prenatal**

529 ☐ Sickle cell anemia (prenatal dx only)**

630119 ☐ GeneSeq PLUS, Prenatal (sequencing with del/dup & VUS)**∞

630102 ☐ GeneSeq PLUS without VUS, Prenatal (sequencing with del/dup, without VUS)**∞

Required gene(s): _____

Thrombophilia‡

549 ☐ Factor II (prothrombin, G20210A)

548 ☐ Factor V (Leiden)

526 ☐ MTHFR

Other test: _____

◊ X-linked disorders are not tested in males
∞ Not available in New York State
^Available for blood specimens only
*Fragile X is for females only #Dx test for prenatal samples/symptomatic/family history
** Maternal cell contamination analysis required for all prenatal dx (send a maternal sample).

Clinical Information (‡If not checked, screening assumed)

Parental: ☐ No family history ☐ Abnormal fetal U/S* ☐ Family hx: relative*
☐ Known carrier* ☐ Thrombophilia* ☐ Infertility
☐ Egg donor ☐ Sperm donor

Fetal: ☐ Abnormal fetal U/S* ☐ Family hx: relative* ☐ Parent(s) known carrier(s)*

*Provide additional information: _____

†Reflex policy: The following will be performed at additional charge: AChE when AF-AFP is elevated &/or GA is out of range of normative values; Fetal HGB when AF-AFP is elevated & amniotic fluid is bloody; Southern blot analysis when Fragile X PCR result is >54 CGG repeats; SMN2 analysis when SMN1 result is 0 copies.

Maternal Serum/Plasma Screening

451927 ☐ MaterniT® 21 PLUS (9w+)

451931 ☐ MaterniT® 21 PLUS + ESS (9w+)◆

451934 ☐ MaterniT® 21 PLUS + SCA (9w+)†**

451937 ☐ MaterniT® 21 PLUS + ESS + SCA (9w+)◆†**

451951 ☐ MaterniT® 21 PLUS No Gender (9w+)

451941 ☐ MaterniT® GENOME (9w+)**

452104 ☐ GENOME-Flex (Add On)**

452114 ☐ GENOME-Flex (Add On) Redraw**

◆ ESS = chr 16, chr 22, and select microdeletions
†SCA = sex chromosome aneuploidies

315 ☐ FirstScreen®* (10w 3d – 14w 0d)

335 ☐ SequentialScreen℠*

302 ☐ IntegratedScreen℠*

302 ☐ Serum IntegratedScreen℠* (without NT measurement)

325 ☐ AFP4® (15w 0d – 21w 6d)

310 ☐ MSAFP (ONTD only; 15w 0d – 23w 6d)

Other _____

*Dried blood spot samples acceptable for first trimester only.
**singletons only

Cytogenetics/FISH/Biochem *

105 ☐ InSight® (FISH for 13, 18, 21, X, Y)
☐ Reflex to SNP if InSight normal or reflex to chromosomes if InSight abnormal
☐ Chromosome analysis
☐ Reflex to SNP if chromosomes normal
☐ Reflex to SNP if POC chromes fail to grow
☐ Other:_____

477 ☐ Reveal® SNP Microarray (GA required)
☐ add MCC to SNP

287 ☐ DiGeorge/VCF (22q11.2 deletion) (FISH)

300 ☐ AF-AFP

330 ☐ Acetylcholinesterase (AChe)

☐ Parental blood for:_____

Clinical Information: Maternal Serum/Plasma Screening or Cytogenetics/FISH/Biochem

Gravida: Para: SAB: TAB: # Fetuses^: 1 ☐ 2 ☐ >2 ☐ Repeat Screen ☐

Sonographer Name: NTQR ID#:

Reading MD NTQR ID#: Practice Location ID#:

U/S date: / / GA on U/S date: wks days Maternal Weight lbs.

NT: mm CRL: mm For Twin: NT: mm CRL: mm

LMP date: / / EDC date: / / by ☐ U/S ☐ LMP ☐ PE ☐ IVF

Fetal Sex, if known: ☐ Female ☐ Male

IVF fertilization date^^: / / IVF egg donor: ☐ Self ☐ Non-Self Donor Age:

^Assume 1 if left blank ^^Assume non IVF if left blank

Y ☐ N ☐ Patient is Rx-dependent diabetic prior to pregnancy ☐ Insulin/Oral hypoglycemics

Y ☐ N ☐ Previous pregnancy/child with Down syndrome

Y ☐ N ☐ Family hx of: ☐ NTD, specify: Relative:

Y ☐ N ☐ Family hx of: ☐ Chromosome abnormality✧ ☐ ID✧ ☐ Other✧

☐ AMA ☐ Multiple Spontaneous Abortions (SAB) ☐ Routine Prenatal Screening

☐ Positive serum screen: ☐ NTD ☐ Down syndrome ☐ Trisomy 18

☐ Abnormal fetal U/S: ☐ CNS✧ ☐ Increased risk of aneuploidy ☐ Other✧

☐ Parental cytogenetics following abnormal prenatal results✧

☐ Parental balanced Robertsonian Translocation with increased risk of Trisomy

✧Provide additional information: _____

All diagnoses should be provided by the ordering physician or an authorized designee.
Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required)

ICD-CM		ICD-CM		ICD-CM	

BILLING INFORMATION

Patient Hospital Status: ☐ Inpatient ☐ Outpatient ☐ Non-hospital

☐ Medicaid ☐ Medicare ☐ Insurance ☐ Client Bill ☐ CA XAFP ☐ Self-Pay

☐ Billing Information Attached (Please include a copy of insurance card or face sheet.)

Do not attach credit card information to this form for security purposes.

Insurance Company Name _____

Policy # _____ Group # _____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Patient Signature _____ Date: _____

INTEGRATED GENETICS INTERNAL USE ONLY

By signing this form, I hereby authorize Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to LCAH.

I understand that I am responsible for any amounts not paid by insurance for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.

* For SNP Microarray, if DNA is sent, the lab only accepts isolated or extracted nucleic acid for which extraction or isolation is performed in an appropriately qualified CLIA or CAP/CMS equivalent laboratory