GENETIC CARRIER & PRENATAL SCREENING

progenity® AVERO™

→ PLEASE PRINT Print clearly in uppercase letters.

FEMALE PATIENT ☐ MALE PATIENT - Z31.440

LAST NAME

FIRST NAME

DATE OF BIRTH (MM/DD/YYYY) | TELEPHONE NUMBER

☐ Asian ☐ African American ☐ Hispanic
☐ Caucasian ☐ Jewish, Ashkenazi ☐ Other/Mixed/Unknown _____

E-MAIL

STREET NUMBER | STREET NAME | APT NUMBER

CITY | STATE | ZIP

ACKNOWLEDGEMENT: I authorize the laboratory to provide to my health plan the information on this form and other information provided by my healthcare provider if necessary for reimbursement. I understand that the laboratory may seek prior authorization for testing from my health plan on my behalf. I also authorize all benefits of the plan to be payable directly to the laboratory, and I agree to remit to the laboratory any payment for these services made directly to me. I understand that the laboratory may be an out-of-network provider for my health plan and that I am responsible for all amounts not reimbursed by my health plan. I hereby designate the laboratory as my Authorized Representative, as provided under ERISA, 29 C.F.R. § 2560.5031 (b)(4), and/or as my Attorney in Fact, for the purpose of pursuing administrative appeals to which I am entitled and, if the laboratory deems it appropriate, any legal and/or equitable claims that I could bring against my health plan, and/or its fiduciaries, and/or its administrators, with respect to their handling or resolution of my insurance claim. I authorize information to be shared with my partner if also undergoing testing.

☐ I authorize the laboratory to retain and use my de-identified specimen and test data (where all information that could link me to the specimen or data has been removed) for research and/or help develop new products or services, in compliance with applicable laws.
☐ I do not authorize the laboratory to retain and use my de-identified specimen and test data as described above.

If signature is present but box is not checked, consent is implied. All leftover specimens from New York State will be destroyed within 60 days.

REQUIRED PATIENT SIGNATURE X DATE (MM/DD/YY)

CLINICIAN INFO

PROGENITY ACCOUNT NUMBER

ORDERING CLINICIAN NAME

CLINIC NAME

TELEPHONE NUMBER | FAX NUMBER

ADDRESS / CITY / STATE / ZIP

ACKNOWLEDGEMENT: I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given consent as required under applicable laws and regulations for the test(s) to be performed. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purposes for this patient. I confirm that the person listed as the Ordering Clinician is authorized by law to order the tests(s) requested herein.
☐ The patient has completed pre-testing genetic counseling.

REQUIRED ORDERING CLINICIAN SIGNATURE X DATE (MM/DD/YY)

ADDITIONAL REPORTS TO: CLINICIAN NAME

NPI# | FAX NUMBER

BILLING INFO

☐ **BILL INSURANCE** Attach legible front and back copy of insurance cards.

NAME OF INSURED

INSURANCE COMPANY | PRE-AUTHORIZATION #, IF OBTAINED

MEMBER ID | GROUP #

☐ **BILL PATIENT** Please call us to review payment options. ☐ **BILL ORDERING CLINICIAN**

Collection Requirement Key: See Progenity Specimen Guide for additional specimen types (4) 4 mL Lavender-top EDTA tube (8.5) 8.5 mL Yellow-top ACD tube (10) 10 mL Streck DNA tube (4) 4 mL serum separator tube (SST)

SPECIMEN INFO: Date Collected (MM/DD/YY) _____ Time Collected _____ ☐AM ☐PM Collected by: _____

PREPARENT® CARRIER TEST

☐ 3500 **Standard Panel**[1,2,3] tests carrier status of 29 disorders with ACOG/ACMG guidelines *For list of disorders tested, visit progenity.com/resources/standard* — 2 x (4)

☐ 3501 **Global Panel**[1,2,3] tests carrier status of 200+ disorders *For list of disorders tested, visit progenity.com/resources/global* — 2 x (4)

☐ 3502 **Global+ Panel**[1,2,3] tests carrier status of 220+ disorders *For list of disorders tested, visit progenity.com/resources/global* — 2 x (4)

☐ 5010 5020 **Exon Panel** tests carrier status of 150+ disorders with full exon sequencing *For list of disorders tested, visit progenity.com/resources/exon* — 1 x (4)

☐ 3901 **Trio Panel**[2,3] tests carrier status of CF, SMA, and FX with reflex to Xpansion Interpreter® for results of 55 – 90 CGG repeats — 1 x (4)

☐ 2004 **Cystic Fibrosis** (600 mutations) — 1 x (4)

☐ 2400 **Spinal Muscular Atrophy** — 1 x (4)

☐ 2500 **Fragile X Syndrome**[3] with reflex to Xpansion Interpreter® for results of 55 – 90 CGG repeats — 1 x (4)

☐ 3300 **Hemoglobin Evaluation** includes sickle cell *(see description on reverse)* — 1 x (4)

☐ 2300 **Ashkenazi Jewish Panel** tests carrier status of 9 common Jewish disorders — 1 x (4)

☐ **Other** (All tests can be ordered individually.) _____

☐ 2201 [1] *OPT IN for Tay-Sachs Hexosaminidase A enzyme analysis* — 1 x (8.5)

☐ 3800 [2] *OPT IN for Preparent® XY Fetal Sex Option (gestational age 10 weeks or later)* — 1 x (10)

☐ 2502 [3] *OPT OUT of reflex to Xpansion Interpreter® for Fragile X results with 55 – 90 CGG repeats*

The Standard, Global, and Global+ panels all include testing for CF, SMA, fragile X, Ashkenazi Jewish disorders, and a hemoglobin evaluation. Carrier testing for X-linked disorders is not performed in males.

ANEUPLOIDY SCREENING

INNATAL® PRENATAL SCREEN noninvasive *(Gestational age 10 weeks or later)*

☐ 2800 **Singleton Pregnancy** noninvasive screening for chromosomes 21, 18, 13, X and Y — 1 x (10)
☐ *OPT OUT of screening for sex chromosome aneuploidies (no fetal sex information)*

☐ 2800 **Twin Pregnancy** noninvasive screening for chromosomes 21, 18, 13, and Y — 1 x (10)
☐ *OPT OUT of screening for Y chromosome (no fetal sex information)*

MATERNAL SERUM SCREENING

☐ 2901 **First Trimester Screen** (PAPP-A, hCG) — 1 x (4)
Gestational age 11 – 13 weeks 6 days
❗ *Requires nuchal translucency ultrasound.*
For twins, attach separate form: progenity.com/ultrasound

☐ 2902 **Second Trimester Quad Screen** (AFP, uE3, hCG, DIA) — 1 x (4)
Gestational age 15 – 22 weeks 6 days

☐ 2900 **Open Neural Tube Screen** (AFP) — 1 x (4)
Gestational age 15 – 22 weeks 6 days

ULTRASOUND INFORMATION

Ultrasound date

Crown rump length mm (34.0 – 85.0)

Nuchal translucency mm

Nasal Bone ☐Not evaluated ☐Present ☐Absent

Sonographer Name

Sonographer ID

Credentialed by ☐NTQR ☐FMF ☐Other

CLINICAL INFO (REQUIRED)

FOR FEMALE PATIENTS ONLY

Is female patient pregnant?
☐ YES (select box to right)
☐ NO Z31.430

First pregnancy (primigravida)
☐1st tri Z34.01 ☐2nd tri Z34.02 ☐3rd tri Z34.03

Not first pregnancy (multigravida)
☐1st tri Z34.81 ☐2nd tri Z34.82 ☐3rd tri Z34.83

GESTATIONAL **AGE AT DRAW** WEEKS DAYS | ESTIMATED DATE OF DELIVERY (MM/DD/YY)

DATING METHOD ☐LMP ☐Ultrasound ☐Other

PREGNANCY ☐Singleton ☐Twin ☐Other Specify# ☐Unknown

☐ Patient used an egg donor (009.811) AGE OF DONOR

PATIENT HEALTH DATA

PATIENT WEIGHT LBS | PATIENT HEIGHT FT IN

☐ Patient has had a blood transfusion (past 3 months) or a bone marrow/organ transplant
☐ Patient is an insulin-dependent diabetic
☐ Patient smokes cigarettes

PREPARENT ONLY

Is there a family history of genetic disorders?
☐ No
☐ Hereditary genetic disorder Z84.81
☐ Musculoskeletal disorder Z82.69

SPECIFY CONDITION:

RELATIONSHIP TO PATIENT OR PARTNER:

Has patient had previous carrier testing?* ☐YES ☐NO *If yes, attach report
Is partner available for testing, if needed? ☐YES ☐NO

PARTNER'S DATE OF BIRTH (MM/DD/YYYY) | PARTNER'S NAME (OPTIONAL)

OTHER DIAGNOSIS (SPECIFY ICD-10)

INNATAL ONLY

PATIENT IS AT INCREASED RISK FOR ANEUPLOIDY DUE TO:

Advanced Maternal Age (AMA)
AMA 1st pregnancy (primigravida)
☐1st tri O09.511 ☐2nd tri O09.512
AMA not 1st pregnancy (multigravida)
☐1st tri O09.521 ☐2nd tri O09.522

☐Abnormal serum screening O28.1
☐Ultrasound indicating structural anomaly O28.3
☐Prior pregnancy w/aneuploidy Z82.8
☐Other_____

OTHER DIAGNOSIS (SPECIFY ICD-10)

WH-27007-01 REV 082018

PATIENT NAME_____ DATE OF BIRTH_____ | PATIENT NAME_____ DATE OF BIRTH_____ | PATIENT NAME_____ DATE OF BIRTH_____ | PATIENT NAME_____ DATE OF BIRTH_____

HEMOGLOBIN EVALUATION

Red blood cell count
Hemoglobin
Hematocrit
Mean corpuscular volume (MCV)
Mean corpuscular hemoglobin (MCH)
Red cell distribution width (RDW)
Hemoglobin electrophoresis

CLINICAL INDICATIONS

GENETIC CARRIER SCREENING

Screening for other metabolic disorders Z13.228
Nonprocreative screening for genetic disease carrier status Z13.71
Female for testing for genetic disease carrier status for procreative management Z31.430
Male for testing for genetic disease carrier status for procreative management..... Z31.440
Supervision of normal first pregnancy, first trimester..... Z34.01
Supervision of normal first pregnancy, second trimester Z34.02
Supervision of other normal pregnancy, first trimester Z34.81
Supervision of normal pregnancy, unspecified, first trimester Z34.91
Family history of intellectual disabilities Z81.0
Family history of other diseases of the musculoskeletal system and connective tissue..... Z82.69
Family history of carrier of genetic disease Z84.81

PRENATAL ANEUPLOIDY SCREENING

Supervision of pregnancy with history of infertility, first trimester O09.01
Supervision of pregnancy with history of infertility, second trimester O09.02
Supervision of pregnancy with other poor reproductive or obstetric history, first trimester O09.291
Supervision of pregnancy with other poor reproductive or obstetric history, second trimester O09.292
Supervision of elderly primigravida, first trimester O09.511
Supervision of elderly primigravida, second trimester O09.512
Supervision of elderly multigravida, first trimester O09.521
Supervision of elderly multigravida, second trimester O09.522
Supervision of pregnancy resulting from assisted reproductive technology, first trimester O09.811
Supervision of pregnancy resulting from assisted reproductive technology, second trimester O09.812
Supervision of other high risk pregnancies, first trimester O09.891
Supervision of other high risk pregnancies, second trimester O09.892
Abnormal hematological finding on antenatal screening of mother O28.0
Abnormal biochemical finding on antenatal screening of mother.....O28.1
Abnormal cytological finding on antenatal screening of mother O28.2
Abnormal ultrasonic finding on antenatal screening of mother O28.3
Abnormal radiological finding on antenatal screening of mother O28.4
Abnormal chromosomal and genetic finding on antenatal screening of mother O28.5
Other abnormal findings on antenatal screening of mother O28.8
Unspecified abnormal findings on antenatal screening of mother.....O28.9
Maternal care for (suspected) chromosomal abnormality in fetus, not applicable or unspecified O35.1XX0
Maternal care for (suspected) hereditary disease in fetus, not applicable or unspecified O35.2XX0
Other screening for genetic and chromosomal anomalies Z13.79
Family history of other disabilities and chronic diseases leading to disablement, not elsewhere classified Z82.8

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