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STAT Prenatal and Fetal Testing Requisition Form

Testing can also be ordered via online portal – please scan or click on QR code.
Please complete every field and tick box clearly.

STEP 1: GESTATIONAL CARRIER'S INFORMATION (FETUS OF)

Patient's First Name | Middle Initial | Patient's Last Name

MM/ DD /YYYY
Patient's Date of Birth | Patient ID/MR Number/External Sample Number

Biological Sex: ○ Male ○ Female ○ Unknown
Gender Identity (if different from above):_____

Patient's Street Address | City / Town

State | Zip Code | Country | Patient's Preferred Phone | Patient's Email

Gestational Carrier's Ethnicity (check all that apply): ○ African-American ○ Asian (China, Japan, Korea) ○ Caucasian/N. European/S. European ○ Finnish ○ French Canadian ○ Hispanic ○ Jewish - Ashkenazi ○ Jewish - Sephardic ○ Mediterranean ○ Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey) ○ Native American ○ E. Indian ○ Southeast Asian (Vietnam, Cambodia, Thailand) ○ South Asian (India, Pakistan) ○ Other (specify)_____

PATIENT SAMPLE INFORMATION

SAMPLE TYPE: ○ Genomic DNA from fetal sample ○ Cultured Amniocytes ○ Cultured CVS ○ Direct Product of Conception (POC) ○ Fetal Tissue-Tissue Type: _____ ○ Cord Blood ○ Other: _____contact lab before sending_____

Collection Date: MM/DD/YY
Was this sample collected in the State of NV, NY or OR?: ○ Yes ○ No
(If yes, separate consent is required. See forms section of website.)

INDICATION FOR TESTING

Clinical Diagnosis:_____ (medical records/clinical notes are required.) Age at Initial Presentation:_____

STEP 2: ORDERING PROVIDER AND REPORTING PREFERENCES

Provider's First and Last Name | NPI

Clinic/Hospital/Institution Name | Provider's Email

Provider's Street Address | City / Town | State | Zip Code | Country

Provider's Phone | Provider's Fax

How would you like to receive the report?:
○ Fax ○ Email ○ Portal

SEND ADDITIONAL COPY OF RESULTS TO (If applicable)

Name | Role with patient/Job title | Clinic/Hospital/Institution Name

Phone Number | Fax Number | Email Address

How would you like to receive the report?:
○ Fax ○ Email ○ Portal

STEP 3: BILLING INFORMATION

☐ **INSTITUTIONAL BILLING**

Institution/Organization Name | Billing Account ID | P.O. Number (if applicable)

Contact Name | Contact Phone

☐ **PATIENT (SELF) PAYMENT**

By providing payment information, you are authorizing Revvity Omics to process payment at the associated charge for tests ordered. Test cost is available on our website, or may be confirmed by calling 877-475-4436. Payment is required prior to test initiation. The patient's sample will be placed on hold (for up to 30 days) until payment is secured. If the patient does not provide payment to Revvity Omics within 30 days, the test order may be canceled. Please note that failure by the patient to respond in a timely fashion to Revvity Omics attempts to obtain payment may cause a delay in the receipt of the results report.

○ **CREDIT CARD** (Please fill out all information below) ○ **CHECK:** $_____ Amount Enclosed (Please make checks payable to: Revvity Omics, Inc.)

Credit Card Number | MM/YY Exp. Date | CVV | Cardholder Printed Name as Appears on Card | Amount

Credit Card Billing Street Address | City / Town | State | Zip Code

Cardholder Signature | Cardholder Phone

○ **CONTACT FOR PAYMENT INFORMATION**

Name | Phone | Email Address

FOR INTERNAL USE ONLY				
Date Rec'd_____	Rec'd _____			
TEMP	SPEC	COL	#TUBES	VOL
R/C/F				
R/C/F				
R/C/F				

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STEP 4: TEST MENU

STAT Whole Exome Sequencing Testing Options

- ○ D1000E STAT Prenatal Whole Exome Sequencing, Proband ONLY
- ○ D1330E STAT Prenatal Whole Exome Sequencing, DUO
- ○ D1310E STAT Prenatal Whole Exome Sequencing, TRIO

STAT Whole Genome Sequencing Testing Options

- ○ D0900E STAT Prenatal Prenatal CNGnome NGS Array
- ○ D2010E STAT Prenatal Whole Genome Sequencing, Proband ONLY
- ○ D2330E STAT Prenatal Whole Genome Sequencing, DUO
- ○ D2310E STAT Prenatal Whole Genome Sequencing, TRIO

Additional Test Code Request (Non-Ongoing Pregnancies Only)

Test Code: _____

Test Name: _____

PREGNANCY STATUS

Ongoing pregnancy? ○ Yes ○ No

MATERNAL CELL CONTAMINATION (MCC) SAMPLE INFORMATION

For samples derived from CVS or amniotic fluid (AF), MCC is mandatory. For all other sample types,MCC is recommended but not required.

- ○ D0990E MCC Test
- ○ Submit MCC report performed in another lab

Targeted Testing Options

○ D0600E STAT Prenatal Single-site testing

Proband Last Name, First Name | Proband DOB (MM/ DD /YYYY)

Proband's Accession ID | Relationship to Proband

Positive Control Sample: ○ Already at Revvity ○ To be sent later ○ Not Available

Gene(s)	Coding Name (c.)	Protein Name (p.)

○ D0999E STAT Prenatal Targeted CNV Analysis

Proband Last Name, First Name | Proband DOB (MM/ DD /YYYY)

Proband's Accession ID | Relationship to Proband

Positive Control Sample: ○ Already at Revvity ○ To be sent later ○ Not Available

Cytoband/Gene	CN Event/Size/Exon	Additional CN Event/Size/Exon

! Please include a copy of relative's report, if available.

STEP 5: FAMILIAL INFORMATION (REQUIRED WITH ALL TRIO/DUO AND MCC STUDIES)

FAMILY MEMBER 1

Last name, First name | Relationship to Patient

Date of Birth: MM/ DD /YYYY Symptomatic (clinically affected): ○ Yes ○ No Sample ○ Included - Collection Date MM/ DD /YYYY ○ To be sent later

Sample type: ○ Whole blood (preferred) ○ Saliva ○ Isolated DNA

FAMILY MEMBER 1

Last name, First name | Relationship to Patient

Date of Birth: MM/ DD /YYYY Symptomatic (clinically affected): ○ Yes ○ No Sample ○ Included - Collection Date MM/ DD /YYYY ○ To be sent later

Sample type: ○ Whole blood (preferred) ○ Saliva ○ Isolated DNA

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STEP 6: PREGNANCY DETAILS AND FAMILY HISTORY

GESTATIONAL AGE AT SAMPLE COLLECTION
Weeks:____ Days:_____ EDD: _____ Based on: ○ LMP ○ Ultrasound

Gestation: ○ Singleton ○ Twins ○ Higher-Order Multiples

Was this pregnancy conceived by IVF? ○ Yes ○ No

Was an egg donor used to conceive this pregnancy? ○ Yes ○ No

Age of donor at egg retrieval: _____

Is the biological mother/egg donor the same as gestational carrier? ○ Yes ○ No

Fetal ultrasound abnormalities identified?
○ Yes ○ No

Fetal sex known?
○ Male ○ Female ○ Unknown ○ Ambiguous

Has gestational carrier had positive serum screen result?
○ Yes ○ No

Has biological mother/gamete donor had previous pregnancy with chromosome abnormality?
○ Yes ○ No

Has any previous genetic testing been performed on the fetus (including preimplantation testing on the embryo)?
○ Yes ○ No If Yes, what?

Does either biological parent or gamete donor have family history of:
• chromosome abnormaility? ○ Yes ○ No If yes: _____
• genetic disease? ○ Yes ○ No If yes: _____

STEP 7: PHYSICIAN CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

The undersigned person (or designated representative thereof) certifies that: (a) he/she is a licensed medical professional authorized to order the testing ordered herein; (b) he/she fully complies with all applicable federal, state, and local laws, regulations, and rules, including but not limited to those governing genetic testing, informed consent, and patient consent and authorization requirements for the test(s) ordered; (c) he/she will obtain informed consent of the patient in compliance with all applicable laws and regulations, which shall include, to the extent applicable: (i) a statement of the purpose of the test(s) ordered; (ii) a statement that prior to signing the consent form, the consenting person discussed with the medical practitioner ordering the test the reliability of positive or negative test results and the level of certainty that a positive test result for that disease or condition serves as a predictor of such disease; (iii) a statement that the consenting person was informed about the availability and importance of genetic counseling and provided with written information identifying a genetic counselor or medical geneticist from whom the consenting person might obtain such counseling; (iv) a general description of each disease or condition tested for; and (v) the person or persons to whom the test results may be disclosed; (d) he/she will maintain, as part of the patient's record, documentation of the patient's informed consent and authorization for the test(s) ordered that complies with applicable laws and regulations, and will make such documentation available to Revvity upon request; (e) tests ordered are medically necessary and results may impact medical management for the patient; and (f) the information provided on this Test Requisition Form is complete, true, and accurate to the best of his/her knowledge.

Signature_____ Date_____

FETAL PHENOTYPES

DETAILED MEDICAL RECORDS, CLINICAL SUMMARY, PICTURES AND FAMILY HISTORY MUST BE ATTACHED FOR ALL CASES.
CLINICAL INFORMATION IS CRUCIAL FOR ACCURATE INTERPRETATION OF RESULTS.

PRIMARY INDICATION (required)
○ Fetal anomaly
○ Cystic hygroma / Increased nuchal translucency size (mm): _____
○ Abnormal NIPS result†
○ Abnormal serum screen†
○ Advanced maternal age†

† CNGnome® testing is recommended for this indication.

Whole genome and exome sequencing will not be performed without additional clinical information.

Previous test results should be sent with order.

GASTROINTESTINAL
○ Absent stomach bubble
○ Diaphragmatic hernia
○ Echogenic bowel
○ Gastroschisis
○ Omphalocele

GROWTH
○ Fetal demise
○ Fetal pyelectasis/hydronephrosis
○ Hydrops fetalis
○ Intrauterine growth retardation (IUGR)
○ Oligohydramnios
○ Polyhydramnios
○ Prematurity
○ Sacrococcygeal teratoma
○ Short long bones
○ Small for gestational age (SGA)
○ Small thorax

NEUROLOGICAL
○ Abnormality of septum pellucidum
○ Absent septum pellucidum
○ Cavum septum pellucidum
○ Choroid plexus cyst (CPC)
○ Decreased fetal movement
○ Encephalocele
○ Myelomeningocele/Spina bifida

CARDIAC
○ Congenital heart defect
○ Intracardiac echogenic focus (IEF)
○ Pericardial effusion

OTHER
○ Absent nasal bone
○ Fetal ascites
○ Generalized edema
○ Pleural effusion

Other: