revvity

Newborn Screening Follow-up Requisition Form

Please complete every field and tick box clearly.

STEP 1: PATIENT INFORMATION

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

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: ○ Saliva Swab ○ Whole Blood ○ Dried Blood Spots ○ Other_____ ○ DNA, Source:_____

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: TEST MENU

NEWBORN SCREENING FOLLOW-UP TESTING

○ **NBS600** Targeted Single Site Analysis

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

Proband's Accession ID | Relationship to Proband

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

Newborn Screening State of Origin

○ Pennsylvania: PADOH ○ Nebraska: NERPT ○ Delaware: DE035 ○ Florida: H1756 ○ Illinois: B0162 ○ Other:
○ Mississippi: MSDH ○ Washington DC: DCDOH ○ California: H1467 ○ Tennessee: H1706 ○ Oregon: B0441 _____

STEP 4: 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 Clinical Genomics Test Requisition Form is complete, true, and accurate to the best of his/her knowledge.

Signature_____ Date_____

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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