Prenatal Test Requisition Form

120 N. Pine St, Suite 152
Spokane, WA 99202
Phone: 844-ALLELE2 (255-3532)
Fax: 509-232-5779
Email: info@allelediagnostics.com

Patient Information

Name: First _____ MI _____ Last _____ Date of Birth (MM/DD/YYYY) _____
Medical Record Number _____ Sex: ☐ Male ☐ Female ☐ Unknown

Provider Information

Physician _____ Genetic Counselor _____
Phone _____ Fax _____ Email _____
Institution _____ Additional reports to _____

Clinical Indication

☐ Advanced maternal age
☐ Abnormal cell-free fetal DNA test _____
☐ Abnormal maternal serum screen _____
☐ Abnormal fetal ultrasound _____
☐ Family history (specify relationship to patient, clinical and lab details) _____
☐ Fetal loss / stillbirth / POC
☐ Parental concern / anxiety
☐ Other _____
☐ Parental specimen (specify ADx# of fetus) _____

Pregnancy History

Gestational age at sample collection _____ ☐ by U/S ☐ by LMP
Fetal sex: ☐ Male ☐ Female ☐ Ambiguous ☐ Unknown
Donor pregnancy? ☐ No ☐ Yes (specify) _____
Ongoing pregnancy? ☐ Yes ☐ No
Multiple gestation pregnancy? ☐ No ☐ Yes (specify) _____
Prior genetic testing (provide results and copy of report) _____

Family History

SNP microarray may detect identity by descent. If parents are related, describe relationship _____
Family member with previous abnormal genetic testing results (specify relationship; provide ADx#, results, or report) _____
_____

Tests Ordered

☐ 110 High-resolution rapid microarray (CGH and SNP)
☐ 111 Targeted rapid microarray with backbone (CGH and SNP)
☐ 201 Standard karyotype (AF or CVS)[1]
☐ 202 Standard karyotype (POC)[1]
☐ 7025 AFP with reflex to AChE (direct amnio only)[1]
☐ 7500 Maternal cell contamination studies (recommended for all arrays)[1]
☐ Secondary specimen requested by Allele (ADx#) _____
☐ Parental testing as recommended in proband report (ADx#) _____
☐ Other testing _____
☐ Perform testing in the following order _____

Specimen Information

Prenatal sample

Collection date (MM/DD/YYYY) _____ Time _____ ☐ am ☐ pm
☐ Amniotic fluid (choose one): ☐ direct ☐ cultured
☐ CVS (choose one): ☐ direct ☐ cultured
☐ DNA (specify source) _____
☐ Fetal blood (PUBS)
☐ Products of conception (choose one, specify source) ☐ direct ☐ cultured
_____
☐ Other (specify source) _____
Will a backup sample be maintained at another location? ☐ No ☐ Yes

Parental samples

☐ Peripheral blood (5 mL NaHep + 5 mL EDTA) ***Preferred parental sample***
☐ Buccal swab (Use iSWAB™ - DNA Collection Kit)
☐ DNA (specify source) _____
☐ Other (specify source) _____

Father's sample (*If billing differs, please submit separate requisition.*)
Father's name _____ Father's DOB _____

Billing

Institutional Bill

Institution _____ Contact Person _____
Address _____ City, State, Zip _____
Phone _____ Email _____ Fax _____

Credit Card Payment

Please call 844-ALLELE2 (255-3532) to pay by credit card.

Use of Specimens: This sample may be stored indefinitely by Allele Diagnostics, Inc. for quality assurance, test validation, or educational purposes after personal identifiers are removed. I can withdraw my consent at any time by contacting the laboratory at 844-ALLELE2 (255-3532). Refusal to permit the use of my sample will not affect my test result. By checking this box ☐ I am indicating that the sample should be used for the tests ordered on this form and disposed of 60 days after testing is complete. All other samples will be retained based on disposal guidelines set forth by the state in which the ordering physician practices.

[1]*Testing performed by a partner laboratory.*

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