Prenatal Test Requisition Form

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

Maternal 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 non-invasive prenatal screening*
☐ Abnormal maternal serum screen*
☐ Abnormal fetal ultrasound*
☐ Family history (see box below)
☐ Fetal loss / stillbirth / POC
☐ Parental concern / anxiety
☐ Parental specimen
ADx# of fetus _____
☐ Other*

***Details:** _____

Patient Testing and Family History

SNP microarray may detect identity by descent. If parents are related, describe relationship _____
Family history prompting testing (e.g. relationship to patient, ADx#, prior test results/report) _____

Pregnancy History

Gestational age at sample collection _____ by ☐ U/S ☐ LMP
Fetal sex: ☐ Male ☐ Female ☐ Ambiguous ☐ Unknown
Ongoing pregnancy? ☐ No ☐ Yes
Donor pregnancy? ☐ No ☐ Yes _____
Multiple gestation pregnancy? ☐ No ☐ Yes _____

Testing

☐ 110 High-resolution rapid microarray (CGH and SNP)
☐ 111 Targeted rapid microarray with backbone (CGH and SNP)
☐ 201/202 Standard karyotype[1]
☐ 7025 AFP with reflex to AChE (direct amnio only)[1]
☐ 7500 Maternal cell contamination testing[1]
☐ Secondary specimen requested by Allele
ADx# _____
☐ Parental testing as recommended in proband report
ADx# _____
☐ Other testing _____

Perform testing in the following order: _____

1 Testing may be performed by a partner laboratory

Specimen Information

Prenatal Sample

Collection date (MM/DD/YYYY) _____ Time _____ ☐ am ☐ pm
☐ Amniotic fluid ☐ Cultured ☐ Direct
☐ CVS ☐ Cultured ☐ Direct
☐ DNA (specify source) _____
☐ Fetal blood (PUBS)
☐ Products of conception (specify source) ☐ Cultured ☐ Direct
_____
☐ Other (specify source) _____

Parental Samples

☐ Peripheral blood (5 mL NaHep + 5 mL EDTA) ***Preferred***
☐ Buccal swab (OraCollect™)
☐ DNA (specify source) _____
☐ Other (specify source) _____

Father's Sample *(If billing differs, submit separate requisition)*

Father's name _____ Father's DOB _____
Father's MRN _____

Will a backup sample be maintained at another laboratory? ☐ No ☐ Yes If no, a backup culture will be maintained by Allele for 2 weeks.

Billing

Institutional Bill

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

Credit Card Payment

Call 844-255-3532 to pay by credit card. Please see our patient-pay billing policy at allelediagnostics.com/ordering/billing.

Use of Specimens: My 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 844-255-3532. Refusal to permit the use of my sample will not affect my test result. Unless otherwise specified, all samples will be retained based on disposal guidelines set forth by the state in which the specimen was collected. 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. ☐

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