panorama™ prenatal screen

Requisition Form

Brought to you by Natera™

Please place collection kit barcode here.

1 PATIENT INFORMATION

Patient Name (Last, First)

Patient DOB (MM/DD/YYYY)

Patient Street Address

City State Zip Code

Telephone Email

Is this patient pregnant? ☐ Y – v22.1 ☐ N

Gestational Age: _____ (weeks) _____ (days) **or** Due Date (MM/DD/YYYY):_____

Patient must be at least 9 weeks 0 days gestational age.

Maternal Weight: _____ lbs. Height:_____ feet _____ inches

To help with the processing of this sample, please indicate the specific diagnoses that make screening medically appropriate for this patient in section 3

Was an egg donor or surrogate used? ☐ Y ☐ N

Is this a multiple gestation pregnancy? ☐ Y ☐ N

Natera is not able to run this test for patients that have used an egg donor or surrogate, or have a confirmed or suspected multiple gestation pregnancy (including vanishing twins).

Will you be submitting a father sample with this case? If sample is not received in the same box as the mother sample, it will not be processed. ☐ Y ☐ N

The presence of a paternal sample in the analysis decreases the possibility of no results.

If yes, provide name of father:_____ DOB:_____ (MM/DD/YYYY)

Patient Acknowledgement

I confirm that I have been informed about the details of the Panorama™ prenatal test, including its risks, benefits and limitations and I voluntarily consent to testing. I understand I am financially responsible for services performed by Natera including any copayments, deductibles, maximum out of pocket expenses, or other amounts deemed 'patient responsibility' prior to test services being performed. I authorize Natera to submit claims to my medical insurance on my behalf, if applicable, with all benefits of my plan made payable directly to Natera.

NOTE: All samples from patients residing in the state of New York will be destroyed within 60 days after test results have been issued.

Patient Signature Date

2 ORDERING CLINICIAN

Organization (3191) UR Medicine Labs

Telephone 585-758-0520

NY

Ordering Clinician:

- ☐ Stephen Bacak
- ☐ Anne Calvaruso
- ☐ Kathy Flynn
- ☐ J. Christopher Glantz
- ☐ Lisa Gray
- ☐ Tulin Ozcan
- ☐ Eva Pressman
- ☐ Ruth Anne Queenan
- ☐ Stephen Sanko
- ☐ Neil Seligman
- ☐ David Seubert
- ☐ Loralei Thornburg
- ☐ Paula Zozarro-Smith
- ☐ _____

Statement of Informed Consent

I confirm that this patient has been informed about the details associated with the genetic test(s) ordered below including its risks, benefits and limitations, and their personal financial obligation and has given consent to testing.

Clinician/Authorized Signature:

If applicable, please complete the following

Patient ID

Accessioning ID

Medical Record #

Zip Code (of clinic)

If you want the results of this specific case to be sent to an additional fax or email than what you indicated on your account setup form, please write those destinations below.

Fax

Email

3 TEST(S) REQUESTED

☐ **THE PANORAMA™ PRENATAL TEST** (Screening chromosomes 21, 18, 13, X & Y, and Triploidy) Date of Blood Draw (MM/DD/YYYY) _____

☐ YES **I want sex of the fetus included in this report.** (This box needs to be marked for sex of the fetus to be included on the report; sex chromosome abnormalities will still be screened for).

Please select all appropriate clinical indications (corresponding numbers represent insurance codes)

- ☐ Advanced maternal age, 1st pregnancy – 659.53
- ☐ Advanced maternal age, not 1st pregnancy – 659.63
- ☐ Abnormal/Positive serum screening – 796.5
- ☐ Family History – V19.8
- ☐ Personal History – V13.89
- ☐ Ultrasound abnormality (ICD-9 code):_____

Complete the following for Abnormal/positive serum screening:

- ☐ A priori age risk:_____
- ☐ Adjusted screening risk:_____ for which condition:_____

Please Note: If insufficient genetic material (DNA) is obtained, a redraw may be requested.

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