PerkinElmer For the Better | PerkinElmer GENOMICS

VANADIS® NIPT and PRE-ECLAMPSIA (PIGF) Requisition Form

Please complete every field clearly. Missing information may result in a delay of sample processing.

PATIENT INFORMATION

First Name | Date of Birth (MM/ DD /YYYY)

Last Name | Patient ID Number

Patient's Street Address

City / Town | State | Postal Code

Country | Patient's Preferred Phone

Patient's Email (Used for communication of insurance coverage and billing information)

ORDERING ACCOUNT

Provider's First and Last Name

PerkinElmer Account Number | NPI

Clinic/Hospital/Laboratory Name

Primary Contact Email | Primary Contact Phone

Account Street Address

City / Town | State | Postal Code

Country | Account Fax

PREGNANCY DETAILS

EDC: MM/ DD /YYYY Dating by: ○ LMP ○ Ultrasound

Maternal Weight: _____ ○ lbs ○ kg Maternal Height: _____ ○ ft/in ○ cm

Fetus Details

○ Singleton ○ Twins If Twins: ○ Monochorionic ○ Dichorionic

Conception Details

Conception Method (select all that apply): ○ Spontaneous/Natural ○ IVF ○ ICSI ○ PGS/PGT-A ○ Ovulation drugs ○ Other assisted reproduction

If IVF pregnancy, egg source: ○ Self ○ Donor

Age of donor/self at time of extraction:_____

Maternal History

	Yes	No
Insulin Dependent Diabetes Mellitus (IDDM)	○	○
Diabetes Type II	○	○
If yes, is she using insulin?	○	○
Smoking	○	○
Is this patient's first pregnancy?	○	○

If no, number of pregnancies after 24 weeks:_____

ETHNICITY (check all that apply):

○ African American
Asian
○ Indian subcontinent
○ Chinese
○ Filipino
○ Japanese
○ Korean
○ Other Asian descent
○ Caucasian - Non Hispanic
○ French Canadian
○ Hispanic
○ Jewish - Ashkenazi
○ Mediterranean
○ Middle Eastern
○ Native American
○ Pacific Islander
○ Other (specify):_____

PATIENT SAMPLE AND CLINICAL INDICATION

Collection Date:MM/DD/YY Was this sample collected in NY State: ○ Yes ○ No

ICD-10 code(s) required:

AMA Primigravida: ○ 1st trimester - 009.511 ○ 2nd trimester - 009.512
AMA Multigravida: ○ 1st trimester - 009.521 ○ 2nd trimester - 009.522
○ Supervision of normal pregnancy - Z34.90
○ Abnormal ultrasonic finding - 028.3
○ Abnormal serum screening - 028.1
○ Abnormal finding unspecified - 028.9
○ History of recurrent pregnancy loss - 026.20
○ Maternal care for (suspected) chromosomal abnormality in fetus - 035.1XX0
○ Other ICD-10: _____

TEST MENU (check all that apply)

NIPT Testing Options: Please Fill Out Section 1 Below if selected

Vanadis® NIPT (Trisomies 21, 18, 13 only)
○ VAN110 with fetal sex determination
○ VAN100 without fetal sex determination
Vanadis® NIPT (Trisomies 21, 18, 13 and sex chromosome anomalies)
○ VAN120 with fetal sex determination
○ VAN130 without fetal sex determination

! Vanadis - Whole blood in two 10ml Speckled Top Cell Free BCT Tubes required

PIGF PRE-ECLAMPSIA Testing Options: Please Fill Out Section 2 Below if selected

○ PGF100 PIGF for pre-eclampsia screening

! PIGF - Pre-Eclampsia Whole blood in one 10ml red top tube required

Section 1: Required for NIPT Testing Only (select all that apply)

	Yes	No
Abnormal ultrasound findings in current pregnancy	○	○
Positive serum screen in current pregnancy	○	○
Patient or father of pregnancy with a family history of chromosome abnormality	○	○
Patient or father of pregnancy with history of recurrent pregnancy loss	○	○
Previous Pregnancy – Trisomy 21	○	○
Previous Pregnancy – Trisomy 18	○	○
Previous Pregnancy – Trisomy 13	○	○
Previous pregnancy with any chromosome abnormality	○	○

If yes to any items, please specify: _____

Section 2: Required for PIGF and Pre-Eclampsia Testing Only

Mean Arterial Pressure (MAP) Details **! Increases detection rate by > 19%**

Blood Pressure Measure Date:MM/ DD /YYYY

	Left Arm		Right Arm	
Blood Pressure (mm/HG)	Systolic	Diastolic	Systolic	Diastolic
First Reading				
Second Reading				

Scan Details **! Increases detection rate by > 49%**

Date of Ultrasound:MM/ DD /YYYY

CRL (mm) - for twins, use larger of the two measurements: _____

Uterine Artery Pulsatility Index (UTPI) [Acceptable Range: 0.4-4]	Left	Right	Mean

Maternal History

	Yes	No
Chronic Hypertension	○	○
Anti-phospholipid antibody syndrome or Systemic lupus erythematosus	○	○
Mother of Patient had Pre-eclampsia	○	○
Patient or father of pregnancy with history of recurrent pregnancy loss	○	○
Previous Pregnancy - Pre-eclampsia	○	○

If yes: Delivery date:MM/ DD /YYYY

Gestational age:____wks. Baby's birth weight:_____ lbs/ozs.

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate informed consent for the testing ordered, including a discussion of the benefits and limitations. I confirm that testing is medically necessary and that test results may impact medical management for the patient. Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the informed consent and/or attached letter of medical necessity.

Signature_____ Date_____

authorized medical professional

FOR INTERNAL USE ONLY

Date Rec'd_____ Rec'd _____

TEMP SPEC COL #TUBES VOL

R/C/F

R/C/F

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VANADIS® NIPT and PRE-ECLAMPSIA (PIGF) Requisition Form (page 2)

PAYMENT INFORMATION

■ INSTITUTIONAL BILLING (Please ensure all fields in Ordering Account section on page 1 are complete)

Billing Account Name

Billing Account Number

Contact Name

Contact Number

■ PATIENT BILLING

○ **Credit Card** (Please fill out all information): ○ **Check:** $_____ Amount Enclosed (Please make checks payable to: PerkinElmer Genetics, Inc.)

Credit Card Number | CVV | Card Exp. Date (MM/YY) | Billing Zip Code

Cardholder Printed Name as Appears on Card

Cardholder Signature

■ INSURANCE BILLING (Include a copy of both sides of insurance card)

Insurance Carrier and ID

Prior Authorization # (attach confirmation)

Policy Holder Name

Policy Holder DOB (MM/ DD /YYYY)

Policy Holder Relationship to Patient:
○ Self ○ Parent ○ Spouse ○ Other:_____

ADDITIONAL INFORMATION AND INFORMED CONSENT

SAMPLE AND DATA RETENTION

Pursuant to laboratory best practices, your sample will be retained by PerkinElmer for a minimum of two years and then destroyed. Additionally, your PHI, the data from the Tests (including those performed before any withdrawal of consent) and the related reports will be retained by PerkinElmer indefinitely, unless otherwise noted. In some instances, it may be beneficial to you for PerkinElmer to retain your sample for a longer period of time in order to conduct additional testing, and PerkinElmer will do so with appropriate documentation from you or your HCP.

PerkinElmer is requesting consent to keep your anonymized sample and data indefinitely for ongoing test development, scientific research, and/or other activities. This consent is optional, and the Test will be performed whether or not you provide consent to the following:

If consent is given for Sample retention, PerkinElmer will anonymize and retain your Sample indefinitely for internal quality control, test validation, assay development and improvement. By allowing PerkinElmer to retain your Sample, you understand and agree that you give up any property rights you may have in the Sample and are donating it to PerkinElmer Genetics, Inc. If you withdraw your consent, no additional tests or anonymization will be carried out on your Sample; no results will be reported and your sample, reports and data that have not been anonymized will be destroyed.

If consent is given for data retention, PerkinElmer will anonymize your data and retain the anonymized data and related anonymized reports from your Tests indefinitely for internal statistical, quality analysis, research, scientific and technical development, and market research.

PerkinElmer is requesting consent to keep your anonymized sample indefinitely for ongoing test development, scientific research, and/or other activities.
○ Check here if you would like to opt out of anonymized sample retention. Note, if not checked, this is interpreted as “consent given”.

PerkinElmer is requesting consent to keep your anonymized data indefinitely for ongoing test development, scientific research, and/or other activities.
○ Check here if you would like to opt out of anonymized data retention. Note, if not checked, this is interpreted as “consent given”.

PATIENT INFORMED CONSENT

I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists. I hereby authorize PerkinElmer Genetics, Inc. (“PerkinElmer”) to bill my designated insurance carrier(s) and share health information as needed for the purposes of billing and reimbursement, and I request that payment of authorized benefits be made on my behalf to PerkinElmer for any services furnished the patient listed above by PerkinElmer. If any insurance benefits are remitted to me for services performed by PerkinElmer for the patient, I will forward said benefits to PerkinElmer. I authorize PerkinElmer to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. I agree to pay all charges for services provided by PerkinElmer to the patient which are not covered by my health insurance plan or which I am responsible for payment under my health insurance plan. Furthermore, I grant PerkinElmer permission to share health information with my insurance as needed for the purposes of billing and reimbursement.

By signing below I attest that I have read and understood the information in this Patient Informed Consent and I have had my questions about the testing to be performed answered by my healthcare provider. I attest that all information I have provided is accurate, and I consent to PerkinElmer performing the testing ordered by my healthcare provider.

Patient Signature_____ Patient Name_____ Date_____

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