

# VANADIS® NIPT Requisition Form

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

## PATIENT INFORMATION

First Name

Date of Birth

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

Estimated Date of Delivery: \_\_\_\_\_ 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)	<input type="radio"/>	<input type="radio"/>
Diabetes Type II	<input type="radio"/>	<input type="radio"/>
If yes, is she using insulin?	<input type="radio"/>	<input type="radio"/>
Smoking	<input type="radio"/>	<input type="radio"/>
Is this patient's first pregnancy?	<input type="radio"/>	<input type="radio"/>
If no, number of pregnancies after 24 weeks: _____		

### ETHNICITY (check all that apply):

<input type="radio"/> African American	<input type="radio"/> Caucasian - Non Hispanic
<input type="radio"/> Asian	<input type="radio"/> French Canadian
<input type="radio"/> Indian subcontinent	<input type="radio"/> Hispanic
<input type="radio"/> Chinese	<input type="radio"/> Jewish - Ashkenazi
<input type="radio"/> Filipino	<input type="radio"/> Mediterranean
<input type="radio"/> Japanese	<input type="radio"/> Middle Eastern
<input type="radio"/> Korean	<input type="radio"/> Native American
<input type="radio"/> Other Asian descent	<input type="radio"/> Pacific Islander
	<input type="radio"/> Other (specify): _____

## 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. I attest that 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

## PATIENT SAMPLE AND CLINICAL INDICATION

Collection Date: \_\_\_\_\_ Was this sample collected in NY State:  Yes  No

**ICD-10 code(s) required:**

Screening for genetic and chromosomal anomalies – Z13.79  
 Supervision of normal pregnancy - Z34.90

AMA Primigravida:  1st trimester - 009.511  2nd trimester - 009.512  
 AMA Multigravida:  1st trimester - 009.521  2nd trimester - 009.522

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 (select one)

**NIPT Screening Options:**

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**

## Required for NIPT Screening (select all that apply)

	Yes	No
Abnormal ultrasound findings in current pregnancy	<input type="radio"/>	<input type="radio"/>
Positive serum screen in current pregnancy	<input type="radio"/>	<input type="radio"/>
Patient or father of pregnancy with a family history of chromosome abnormality	<input type="radio"/>	<input type="radio"/>
Patient or father of pregnancy with history of recurrent pregnancy loss	<input type="radio"/>	<input type="radio"/>
Previous Pregnancy – Trisomy 21	<input type="radio"/>	<input type="radio"/>
Previous Pregnancy – Trisomy 18	<input type="radio"/>	<input type="radio"/>
Previous Pregnancy – Trisomy 13	<input type="radio"/>	<input type="radio"/>
Previous pregnancy with any chromosome abnormality	<input type="radio"/>	<input type="radio"/>
If yes to any items, please specify: _____		

FOR INTERNAL USE ONLY				
Date Rec'd _____	Rec'd _____			
TEMP	SPEC	COL	#TUBES	VOL
R/C/F				
R/C/F				

**PAYMENT INFORMATION**

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

<input type="text"/>	<input type="text"/>
Billing Account Name	Billing Account Number
<input type="text"/>	<input type="text"/>
Contact Name	Contact Number

**■ PATIENT BILLING**

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Credit Card Number	CVV	Card Exp. Date	Billing Zip Code
<input type="text"/>	<input type="text"/>		
Cardholder Printed Name as Appears on Card	Cardholder Signature		

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

<input type="text"/>	<input type="text"/>
Insurance Carrier and ID	Prior Authorization # (attach confirmation)
<input type="text"/>	<input type="text"/>
Policy Holder Name	Policy Holder Relationship to Patient:
<input type="text"/>	Policy Holder DOB
	<input type="radio"/> Self <input type="radio"/> Parent <input type="radio"/> Spouse <input type="radio"/> 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 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 statistical, quality analysis, research, scientific and technical development, and market research. PerkinElmer may also share your anonymized data and anonymized report with third parties."

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".

**WITHDRAWAL OF CONSENT**

I understand this consent is voluntary and is valid until I withdraw my consent. I understand I may withdraw my consent to sample and data retention, and to the Test at any time, and that PerkinElmer will not perform the Test unless I provide consent to the Test. If I withdraw my consent, it will not affect actions taken before I withdrew my consent, including any anonymization of data or my Sample. I understand that if I wish to withdraw my consent I should contact PerkinElmer via email at: Genomics@perkinelmer.com or toll-free by telephone at +1-866-354-2910 to request withdrawal.

**PATIENT CONSENT TO TESTING AND BILLING ACKNOWLEDGEMENT**

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