

PRESEK NON-INVASIVE PRENATAL SCREENING REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Fetus of: _____ Patient Last Name _____ Patient First Name _____ MI _____ Date of Birth (MM / DD / YYYY) _____

Address _____ City _____ State _____ Zip _____ Phone _____

Accession # _____ Hospital / Medical Record # _____

Patient discharged from the hospital/facility: Yes No

Biological Sex: Female Male Unknown
 Gender identity (if different from above): _____

REPORTING RECIPIENTS

Ordering Physician _____ Institution Name _____

Email (Required for International Clients) _____ Phone _____ Fax _____

ADDITIONAL RECIPIENTS

Name _____ Email _____ Fax _____

Name _____ Email _____ Fax _____

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

SELF PAYMENT
 Pay With Sample Bill To Patient

INSTITUTIONAL BILLING
 Institution Name _____ Institution Code _____ Institution Contact Name _____ Institution Phone _____ Institution Contact Email _____

INSURANCE
 REQUIRED ITEMS 1. Copy of the Front/Back of Insurance Card(s) 2. ICD10 Diagnosis Code(s) 3. Name of Ordering Physician 4. Insured Signature of Authorization

Name of Insured _____	Insured Date of Birth (MM / DD / YYYY) _____	Name of Insured _____	Insured Date of Birth (MM / DD / YYYY) _____
Patient's Relationship to Insured _____	Phone of Insured _____	Patient's Relationship to Insured _____	Phone of Insured _____
Address of Insured _____		Address of Insured _____	
City _____ State _____ Zip _____		City _____ State _____ Zip _____	
Primary Insurance Co. Name _____	Primary Insurance Co. Phone _____	Secondary Insurance Co. Name _____	Secondary Insurance Co. Phone _____
Primary Member Policy # _____	Primary Member Group # _____	Secondary Member Policy # _____	Secondary Member Group # _____

By signing below, I hereby authorize Baylor Genetics to provide my insurance carrier any information necessary, including test results, for processing my insurance claim. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates, as well as any amounts not paid by my insurance carrier for reasons including, but not limited to, non-covered and non-authorized services. I understand that I am responsible for sending Baylor Genetics any and all payments that I receive directly from my insurance company in payment for this test. Please note that Medicare does not cover routine screening tests.

Patient's Printed Name _____ Patient's Signature _____ Date (MM / DD / YYYY) _____

STATEMENT OF MEDICAL NECESSITY (REQUIRED)

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Physician's Printed Name _____ Physician's Signature _____ Date (MM / DD / YYYY) _____

PRESEEK NON-INVASIVE PRENATAL SCREENING REQUISITION

Fetus of: _____ Patient Last Name _____ Patient First Name _____ MI _____ Date of Birth (MM / DD / YYYY) _____ Biological Sex _____

EGG DONOR INFORMATION (IF APPLICABLE)

Egg Donor Last Name or ID _____ Egg Donor First Name or ID _____ MI _____ Egg Donor Date of Birth (MM/DD/YYYY) _____

TEST OPTION **SAMPLE** **SAMPLE TYPE ***

21203 PreSeek (Egg Donor) - WILL NOT BE BILLED _____ / _____ / _____ Date of Collection (MM / DD / YYYY) Saliva Blood in EDTA

* Refer to Sample Specifications Table (page 3)

ETHNICITIES

BIOLOGICAL MATERNAL ETHNICITY

- African American
- Ashkenazi Jewish
- East Asian (China, Japan, Korea)
- Finnish
- French Canadian
- Hispanic American
- Mennonite
- Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey)
- Native American
- Northern European Caucasian (Scandinavian, UK, Germany)
- Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia)
- South Asian (India, Pakistan)
- Southeast Asian (Vietnam, Cambodia, Thailand)
- Southern European Caucasian (Spain, Italy, Greece)
- Other (Specify): _____

BIOLOGICAL PATERNAL ETHNICITY

- African American
- Ashkenazi Jewish
- East Asian (China, Japan, Korea)
- Finnish
- French Canadian
- Hispanic American
- Mennonite
- Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey)
- Native American
- Northern European Caucasian (Scandinavian, UK, Germany)
- Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia)
- South Asian (India, Pakistan)
- Southeast Asian (Vietnam, Cambodia, Thailand)
- Southern European Caucasian (Spain, Italy, Greece)
- Other (Specify): _____

SAMPLE SPECIFICATIONS TABLE

PATIENT	ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT	SHIPPING INSTRUCTIONS	SPECIAL NOTES
Paternal / Egg Donor	BE	Blood in EDTA tube (purple-top)	3 - 5 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	
Paternal / Egg Donor	SA	Saliva	See Special Notes	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Collected with Oragene DNA Self-Collection Kit.
Maternal	ST	Streck Tube	Two 10mL tubes	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	We recommend that the sample is received in the lab within 72 hours after collection. Samples received in the lab greater than 5 days after date of collection will be rejected.

SAMPLE ICD-10 DIAGNOSIS CODES

The ICD-10 diagnosis code(s) must be defined for the most detailed level of specificity available. The following list of commonly used ICD-10 codes for prenatal testing is not complete. Please refer to the ICD-10 manual for a complete listing. These codes are being provided for informational purposes only; it is ultimately the responsibility of the ordering provider to select the appropriate ICD-10 code supported by the patient's medical record.

- Advanced Maternal Age: Primigravida [009.511(1st trimester); 009.512(2nd trimester); 009.513(3rd trimester); 009.519 (Unspecified trimester)]
- Advanced Maternal Age: Multigravida [009.521(1st trimester); 009.522(2nd trimester); 009.523(3rd trimester); 009.529 (Unspecified trimester)]
- Abnormal Serum Biochemical Screen: 028.1
- Ultrasound Finding: 035.1XX0; 028.3, 028.4, 035.9XX0, 035.9XX1, 035.9XX9
- Positive Test Result for Aneuploidy: 028.5, 028.8, 028.9, 035.1XX1, 035.1XX9
- Personal Family History:
 - Prior pregnancy with trisomy [009.291(1st trimester); 009.292(2nd trimester); 009.293(3rd trimester); 009.299 (Unspecified trimester)]
 - Other High Risk Pregnancies [009.891 (1st trimester); 009.892 (2nd trimester); 009.893 (3rd trimester); 009.899 (Unspecified trimester)]
 - Robertsonian translocation [Q95.0 (Balanced Translocation) Q95.1 (Chromosome Inversion)]

PRESEEK NON-INVASIVE PRENATAL SCREENING REQUISITION

Fetus of: _____ / _____ / _____
 Patient Last Name Patient First Name MI Date of Birth (MM / DD / YYYY) Biological Sex

GENES ANALYZED ON PRESEEK

CRANIOSYNOSTOSIS SYNDROMES

GENE	DISORDER
FGFR2	Antley-Bixler syndrome without genital anomalies or disordered steroidogenesis, Apert syndrome, Crouzon syndrome, Jackson-Weiss syndrome, Pfeiffer syndrome type 1/2/3

NOONAN SPECTRUM DISORDERS

GENE	DISORDER
BRAF	Cardiofaciocutaneous syndrome 1
CBL	Noonan syndrome-like disorder with or without juvenile myelomonocytic leukemia (NSLL)
HRAS	Costello syndrome/Noonan syndrome
KRAS	Noonan syndrome/cancers
MAP2K1	Cardiofaciocutaneous syndrome 3
MAP2K2	Cardiofaciocutaneous syndrome 4
NRAS	Noonan syndrome 6/cancers
PTPN11	Noonan syndrome 1/LEOPARD syndrome/cancers
RAF1	Noonan syndrome 5/LEOPARD syndrome 2
RIT1	Noonan syndrome 8
SHOC2	Noonan syndrome-like disorder with loose anagen hair
SOS1	Noonan syndrome 4
SOS2	Noonan syndrome 9

SKELETAL DISORDERS

GENE	DISORDER
FGFR3	Achondroplasia, CATSHL syndrome, Crouzon syndrome with acanthosis nigricans, Hypochondroplasia, Muenke syndrome, Thanatophoric dysplasia, types I and II
COL1A1	Ehlers-Danlos syndrome, classic and type VIIA, Osteogenesis imperfecta, types I, II, III, and IV
COL1A2	Ehlers-Danlos syndrome, cardiac valvular form and type VIIB, Osteogenesis imperfecta, types II, III, and IV

SYNDROMIC DISORDERS

GENE	DISORDER
JAG1	Alagille syndrome
CHD7	CHARGE syndrome
HDAC8	Cornelia de Lange syndrome 5
NIPBL	Cornelia de Lange syndrome 1
RAD21	Cornelia de Lange syndrome 4
SMC1A	Cornelia de Lange syndrome 2
SMC3	Cornelia de Lange syndrome 3
TSC1	Tuberous sclerosis 1
TSC2	Tuberous sclerosis 2
CDKL5	Epileptic encephalopathy, early infantile, 2
MECP2	Rett syndrome
NSD1	Sotos syndrome 1
SYNGAP1	Intellectual disability, type 5

CONSENT FOR TESTING

PreSeek is a cell-free fetal DNA noninvasive prenatal screen that analyzes fetal disorders in maternal blood. PreSeek screens for genetic disorders that can cause skeletal dysplasias, cardiac defects, multiple congenital anomalies and/or intellectual defects due to variants in the genes included (see list). Both biological parental samples are required for this test; the test cannot be performed without samples from both biological parents. This test is not appropriate for individuals who had a blood transfusion in the last month or a bone marrow transplant.

PreSeek will report only pathogenic and likely pathogenic variants and will not report variants of uncertain significance or benign variants. PreSeek detects predominantly de novo variants (a gene variant that is present in the fetus but not the biological parents) which occur with increasing frequency as paternal age advances. However, this testing may possibly indicate that a parent of the fetus has or is predisposed to one of these genetic disorders tested. PreSeek does not screen for fetal chromosome aneuploidies or other copy number abnormalities.

PreSeek should be ordered by a healthcare provider who should provide appropriate genetic counseling to the patient prior to ordering the test and after receiving results. Results are confidential and will only be disclosed to the ordering healthcare providers, the patient upon request, and third party payers if required. Positive screening results should always be followed-up with an invasive, diagnostic test before any medical decisions are made.

I understand that:

- 1) If the PreSeek results are positive, I should consult my physician or genetic counselor and consider further invasive fetal testing.
- 2) The PreSeek results may inform me of a pathogenic or likely pathogenic variant that is present in only myself or my partner, but may not be present in the fetus. This information is important for me to understand the complete risk for this pregnancy. I understand that a negative PreSeek result does not rule out the possibility of the fetus, myself, or my partner of having a genetic disorder.
- 3) It is possible that additional information may come to light during these studies regarding family relationships. For example, data may suggest that family relationships are not as reported, such as misattributed parentage (e.g. maternal/paternal identity is different than indicated on the requisition). Variant interpretation is based on the family relationship information provided to Baylor Genetics by the ordering healthcare provider.
- 4) The information obtained from the PreSeek test may be used in scientific publications or presentations, but my specific identity will not be revealed in such publications/presentations. Baylor Genetics may reach out to my healthcare provider to obtain more information regarding the outcome of my pregnancy over the next one to two years.

All specimens will be retained in the laboratory in accordance with the laboratory retention policy and, if from New York State, will be discarded within 60 days.

Maternal Patient's Name _____

Maternal Patient's Signature _____ / _____ / _____
 Date (MM / DD / YYYY)

Paternal Patient's Name _____

Paternal Patient's Signature _____ / _____ / _____
 Date (MM / DD / YYYY)

Egg Donor Patient's Name (if applicable) _____

Egg Donor Patient's Signature (if applicable) _____ / _____ / _____
 Date (MM / DD / YYYY)