

PRENATAL COMPREHENSIVE 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 # _____
 Multiple gestation? Yes No Donor used? Please specify: _____
 If yes, sample from fetus _____ Patient discharged from the hospital/facility: Yes No
 Genetic 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
 Do Not Perform Test Until Patient is Aware of Out-Of-Pocket Costs (excludes prenatal testing)
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) _____

PRENATAL COMPREHENSIVE REQUISITION

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

ETHNICITY

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

SAMPLE

Date of Collection (MM / DD / YYYY) (REQUIRED) ____ / ____ / ____

SAMPLE TYPE

- | | | | |
|---|----------|-----------------------------|-----------------------------|
| <input type="radio"/> Amniotic Fluid | _____ cc | | |
| <input type="radio"/> CVS | _____ mg | <input type="checkbox"/> TA | <input type="checkbox"/> TC |
| <input type="radio"/> Fetal Blood | _____ cc | | |
| <input type="radio"/> Cultured Amniocytes | | | |
| <input type="radio"/> Cultured CVS | | | |
| <input type="radio"/> Extracted DNA from | _____ | | |

 Additional Cultures to be sent later: Yes No

Cultures will be sent from: _____

GESTATIONAL INFORMATION

U/S Date (MM/DD/YYYY) ____ / ____ / ____

Gestational Age on U/S Date: _____ weeks _____ days

LMP Date (MM/DD/YYYY) ____ / ____ / ____

* NOTE: U/S dating increases Amniotic Fluid Alpha Fetoprotein (AFAFP) and Acetylcholinesterase (AChE) performance.

 Was a egg donor used? Yes No

 Was a sperm donor used? Yes No

Note:

1. Extracted DNA/RNA will **only** be accepted if the isolation of nucleic acids for clinical testing occurs in a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by the CAP and/or the CMS.
2. Extracted DNA **cannot** be used for FISH, CMA, AFAFP, AChE, or Fetal Viral Studies.

PARENTAL AND FAMILIAL SAMPLES
Note: Parental samples are required for Chromosomal Microarray Analysis (CMA) and positive control samples are required for known familial variant testing.

 Was a gamete donor used? Egg Sperm

Sample Submitted	Relationship to Fetus	Last Name	First Name	Date of Birth (MM / DD / YYYY)	Date of Collection (MM / DD / YYYY)	Sample Type	Symptomatic? (Attach summary of findings if Yes)
<input type="checkbox"/>	Maternal / Egg Donor			____/____/____	____/____/____	<input type="radio"/> Blood in EDTA (preferred) <input type="radio"/> Buccal Swab <input type="radio"/> Saliva	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/>	Paternal / Sperm Donor			____/____/____	____/____/____	<input type="radio"/> Blood in EDTA (preferred) <input type="radio"/> Buccal Swab <input type="radio"/> Saliva	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/>	Other Family Member			____/____/____	____/____/____	<input type="radio"/> Blood in EDTA (preferred) <input type="radio"/> Buccal Swab <input type="radio"/> Saliva	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/>	Gestational Carrier REQUIRED for MCC studies if different individual from Maternal/ Egg Donor			____/____/____	____/____/____	<input type="radio"/> Blood in EDTA (preferred) <input type="radio"/> Buccal Swab <input type="radio"/> Saliva	<input type="radio"/> Yes <input type="radio"/> No

Note: Prior to ordering testing, please visit our Pregnancy Testing Menu page (<https://catalog.baylorgenetics.com/category/pregnancy>) and Prenatal Sample Requirements page (www.baylorgenetics.com/prenatal-samplerequirements/) on our website. For complex testing questions or known familial variant testing, genetic counselors may be reached via email at gccomms@baylorgenetics.com or by phone at 1-800-411-4363.

PRENATAL COMPREHENSIVE REQUISITION

 Fetus of: _____ / _____ / _____
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INDICATION FOR TESTING (REQUIRED)

- ICD-10 Diagnosis Code(s): _____
- Abnormal U/S (Specify) _____
- Pregnancy at Risk for Specific Genetic Disorder (Complete Known Familial Variant/Disorder Specific Prenatal Testing section on the next page)
- Multiple Pregnancy Losses
- Advanced Maternal Age (AMA)
- Parental Concern
- Abnormal Maternal Screen
- Other Indication (Attach Report and Specify) _____
- NTD TRI 21 TRI 18 Other: _____
- Abnormal cell-free DNA (attach report)
- TRI 13 TRI 21 TRI 18 Other: _____

DISORDER SPECIFIC PRENATAL TESTING

- 6099 Huntington Disease Repeat Expansion Analysis
- 6109 MECP2 Deletion/Duplication Analysis
- 6100 IKBKG Common Deletion Analysis
- 6351 DMD Deletion/Duplication Analysis
- 6105 Myotonic Dystrophy Type 1 Repeat Expansion Analysis
- 6574 FMR1 (Fragile X) CGG Repeat Expansion Analysis

KNOWN FAMILIAL VARIANT PRENATAL TESTING

- 1522 Custom Sequence Analysis - Prenatal

Gene Name _____

Variant Information: c. _____ p. _____

Family member on page 2 with this variant? _____

Variant Information: c. _____ p. _____

- (REQUIRED) Attached Familial Variant Report

NOTICE FOR PRENATAL TESTING: Please be aware that our specimen requirements and quality control measures are compliant with the American College of Medical Genetics (ACMG) Standards and Guidelines for Clinical Genetics Laboratories. While these requirements are intended to provide the highest level of assurance that a single laboratory can offer, the ideal practice to assure the accuracy of prenatal diagnosis testing is through duplicate testing conducted by independent laboratories. We recommend that referring medical professionals make the necessary arrangements for these two independent analyses for their patients prior to performing the prenatal diagnostic procedure. We also recommend that, before testing is ordered, that a Baylor Genetics Genetic Counselor be contacted to discuss this testing.

Provider/Genetic Counselor Acknowledgement: _____

Baylor Genetic Counselor spoken to: _____

PRENATAL COMPREHENSIVE REQUISITION

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

KNOWN FAMILIAL VARIANT/DISORDER SPECIFIC PRENATAL TESTING

Note: Prior to ordering testing for any of the disorders listed, please visit our Prenatal Sample Requirements page on our website (www.baylorgenetics.com/prenatal-sample-requirements/). For complex testing questions or known familial variant testing, genetic counselors may be reached via email at gc@baylorgenetics.com or by phone at 1-800-411-4363.

- | | |
|---|--|
| <input type="checkbox"/> 1522 Custom Sequence Analysis - Prenatal | <input type="checkbox"/> 6109 MECP2 Deletion/Duplication Analysis |
| <input type="checkbox"/> 6099 Huntington Disease Repeat Expansion Analysis | <input type="checkbox"/> 6351 DMD Deletion/Duplication Analysis |
| <input type="checkbox"/> 6100 IKBKG Common Deletion Analysis | <input type="checkbox"/> 6574 FMR1 (Fragile X) CGG Repeat Expansion Analysis |
| <input type="checkbox"/> 6105 Myotonic Dystrophy Type 1 Repeat Expansion Analysis | |

Name of Baylor Genetic Counselor _____ Date (MM/DD/YYYY) _____

Gene Name _____ Baylor Genetics Family # _____

Variant Information: c. _____ p. _____

 (REQUIRED) Attached Familial Variant Report

NOTICE FOR PRENATAL BIOCHEMICAL AND DNA TESTS: Please be aware that our specimen requirements and quality control measures are compliant with the American College of Medical Genetics (ACMG) Standards and Guidelines for Clinical Genetics Laboratories. While these requirements are intended to provide the highest level of assurance that a single laboratory can offer, the ideal practice to assure the accuracy of prenatal diagnosis testing is through duplicate testing conducted by independent laboratories. We recommend that referring medical professionals make the necessary arrangements for these two independent analyses for their patients prior to performing the prenatal diagnostic procedure.

Physician/Counselor Acknowledgement: _____

PRENATAL TESTING OPTIONS

IMPORTANT INSTRUCTIONS FOR CMA and/or FETAL MOLECULAR STUDIES: Parental and familial samples (draw 5-7cc in an EDTA purple-top tube, or buccal swab) required for control and MCC studies. Label with name, DOB, and complete the Parental and Familial Samples section above.

CONCURRENT STUDIES

(Please see reflex column if studies should be done reflexively)

	AF	CVS	Blood	Tissue/POC
AFAFP + AChE*	<input type="checkbox"/> 8550			
AFAFP*	<input type="checkbox"/> 8501			
Aneuploidy FISH (For 13, 18, 21, X and Y; chromosomes or CMA must also be ordered)	<input type="checkbox"/> 8410	<input type="checkbox"/> 8410		
Rapid FISH (13, 18, 21, X, Y)			<input type="checkbox"/> 8425	
Chromosome Analysis	<input type="checkbox"/> 8530	<input type="checkbox"/> 8700	<input type="checkbox"/> 8600 <input type="checkbox"/> 8800	
CMA Comprehensive			<input type="checkbox"/> 8665 <input type="checkbox"/> 8639	
Expanded CMA	<input type="checkbox"/> 8670	<input type="checkbox"/> 8671		
Expanded CMA + Limited Chromosome Analysis	<input type="checkbox"/> 8675	<input type="checkbox"/> 8676		
Targeted CMA	<input type="checkbox"/> 8656	<input type="checkbox"/> 8657		
Targeted CMA + Limited Chromosome Analysis	<input type="checkbox"/> 8673	<input type="checkbox"/> 8672		
Prenatal Noonan	<input type="checkbox"/> BG-24001-P12-5	<input type="checkbox"/> BG-24001-P12-5		

REFLEX STUDIES

(Please see concurrent testing column for additional orders)

- Chromosome Analysis - If chromosomes are normal, add: **
 Expanded CMA Targeted CMA
- Aneuploidy FISH and Chromosome Analysis - If FISH is normal, add: **
 Expanded CMA Targeted CMA
- Aneuploidy FISH and Chromosome Analysis - If chromosomes are normal, add: **
 Expanded CMA Targeted CMA
- Hold Cells for Potential Add-On Testing
 Please specify potential add-on test(s) below:

FETAL VIRAL STUDIES SENDOUT (AMNIOTIC FLUID ONLY)

- 8940 Herpes Simplex Virus, 1 & 2
 8945 Cytomegalovirus (CMV)
 8950 Toxoplasma (TOXO) gondii
 8955 Parvovirus (PARVO) B19

PHYSICIAN NOTES

* AF-AFP and AChE performed at Integrated Genetics
 ** Additional charges will apply, TAT commences from date reflex order is added

INFORMED CONSENT FOR PRENATAL TESTING

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

GENERAL GENETIC TESTING CONSENT

This consent form cannot be used for whole exome sequencing (WES), whole genome sequencing (WGS), biochemical testing, or Huntington disease testing. Consent forms for other tests are located at Baylor Genetics' website (<https://www.baylorgenetics.com/consent/>).

For the purposes of this consent, "I", "my", "you", and "your" can refer to you, your child, your unborn child, or other individual you are the legal representative of.

TEST INFORMATION

Your healthcare provider (doctor, genetic counselor, or other person with medical training) wants to order one or more tests to find a cause for your health issues. This testing can see if there is a cause for your health issues or if there is an increased chance for a health issue to happen to you or your family. Some of these tests look for changes, called variants, in a person's DNA. DNA is our genetic material. You might have testing for variants in one or more genes, specific parts of DNA that are needed for our health. Variants can also be found in other places in the genome (all of the DNA that a person has). Some tests might look for changes in proteins or analytes that cause health issues. The testing ordered will depend on your health issues as well as what is already known about you and your family's genetics. These tests may also explain health issues that your family may have. Even if this test finds the cause of your health issues, this may not help treat or manage those issues.

Before you sign this consent form, you should speak with your healthcare provider. They can help you understand this testing and what it means for your health.

TEST RESULTS

There are several types of test results that may be reported including:

- **Positive:** A variant in the DNA was found that is related to your health issues or a health issue that you are at an increased risk of having in the future. These changes that cause disease are also known as pathogenic variants.
- **Negative:** No variants in the DNA were found that are related to your health issues or that would increase your risk of a health issue in the future.
- **Variant of Uncertain Clinical Significance (VUS):** A variant in the DNA was found that we do not know its effect, if any, on health. More testing may be needed for you or your family if a VUS is found that may be associated with your health issues.
- **Secondary and Incidental Findings:** Testing can sometimes find a variant in the DNA not related to the reason for testing. If this result is expected to affect your health, it is called a secondary or incidental finding.

CONSIDERATIONS AND LIMITATIONS

- You should speak with your provider before signing this consent form to understand the risks, benefits, and alternatives to testing.
- Testing may show you have, or are at increased chance of having, a health issue. It may show that you have an increased chance of having a child with a health issue.
- Even if the variant(s) causing your health issues are found, how these issues might progress or improve with treatment might not be known. Affected family members with the same variant might not be affected like you are.
- Depending on the results of testing, more testing may be needed to understand these results. This testing might be needed for you and/or other family members.
- A negative result does not rule out the chance for health issues. Our knowledge of variants and how they cause disease may change over time as we learn more about genetics. Testing has limitations to what it can find as well.
- Certain factors may lead to incorrect results. These include mislabeled samples, incorrect information in the test order, and rare technical errors.
- More sample may be needed from you if the first sample is not sufficient to complete testing.

PATIENT CONFIDENTIALITY AND SAMPLE RETENTION

- If several family members are tested, knowing the correct biological relationships among them is important. In rare cases, testing can show that family members are not related as expected. If this is found, we may contact the provider who ordered your testing.
- If this testing is requested to be cancelled after the order and sample are sent to the laboratory, please see our Test Cancellation Policy at www.baylorgenetics.com/cancel-test/.
- Only Baylor Genetics and its contracted partners will have access to your sample for the ordered testing. Results from testing will only be released to: (i) a licensed healthcare provider, (ii) those authorized in writing, (iii) the patient or their personal representative, and (iv) those allowed access to test results by law. You have the right to access your test results from Baylor Genetics by providing a written request. You also have the right to request raw data obtained from your sample by providing a written request or HIPAA Authorization Form.
- In rare cases, people with genetic diseases may have problems with health insurance and employment. The U.S. Federal Government has several laws that prohibit discrimination based on test results by health insurance companies and employers. These laws also prohibit unauthorized disclosure of this information. For more information, please visit www.genome.gov/10002077.
- Samples will be kept in the laboratory based on our retention policy. Once testing completes, de-identified sample may be used for test development, quality assurance, and training purposes. Samples are not returned to patients or providers unless requested prior to testing. You and your heirs will not receive payments, benefits, or rights to any resulting products or discoveries.
- The information from your testing may be used in scientific research, publications or presentations, but your specific identity will not be revealed. We may contact your provider to obtain more clinical information about you. Baylor Genetics also performs other types of scientific research and may contact you to see if you would like to be involved.
- Variants found may be submitted to databases. The medical community uses these databases to collect information about how variants might cause disease to improve testing and treatment for patients. An example is ClinVar, a free, public archive of reports on human genetics. Limited clinical information may need to be shared with these databases. In rare cases, this information may be enough to allow you or your family members to be identified.
- For more information on privacy practices at Baylor Genetics, please visit www.baylorgenetics.com/privacy-practices/.

INFORMED CONSENT FOR PRENATAL TESTING

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

USE OF DATA AND SPECIMEN FOR RESEARCH PURPOSES

Biological specimens, test results, and associated information may be used by Baylor Genetics and its research partners for anonymous or coded research purposes, including improving genetic testing, advancing knowledge of genetic conditions, and developing new technologies, including inclusion in de-identified clinical databases, only with the patient's informed consent. Patient data and specimen will not be used for anonymous or coded research, unless authorized by marking below. A patient's decision to decline participation shall not affect their ability to receive testing from Baylor Genetics.

For Oregon patients, please consult the state specific consent form found at www.baylorgenetics.com/forms.

I authorize Baylor Genetics the use of my specimen and de-identified data for research.

FOR SAMPLES FROM NEW YORK STATE RESIDENTS

Samples from New York State residents shall not be included in research without written consent. Samples will not be retained for more than sixty (60) days after receipt by Baylor Genetics, unless authorized by marking below. No tests other than those authorized shall be performed on the samples.

I authorize Baylor Genetics to retain sample(s) longer based on our retention policy for test development, quality assurance, and training purposes.

FINANCIAL AGREEMENT

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. I designate Baylor Genetics as my designated representative for purposes of appealing any denial of benefits by my insurance carrier. I irrevocably assign associated payment to Baylor Genetics, and direct that payment be made directly to Baylor Genetics. Please note, some payers may not cover certain screening tests.

If my health insurer does not cover the test or I do not have health insurance, I have received a good faith estimate of the cost for the genetic testing ordered by my provider and agree to pay for the cost of the genetic testing billed to me by Baylor Genetics based on that good faith estimate. More information is available in Baylor Genetics' No Surprises Act and Good Faith Estimate Notice located at <https://www.baylorgenetics.com/no-surprises-act/>.

A Medicare Advance Beneficiary Notice (ABN) is required for services Medicare identifies as not medically necessary.

PATIENT AUTHORIZATION

By signing this statement of consent, I acknowledge that I have read, understand, and hereby grant my informed consent for genetic testing. I have received appropriate explanations from my healthcare provider about the planned genetic test(s) and possible results. I have been informed by my healthcare provider about the availability and importance of genetic counseling and have been provided with written information identifying a genetic counselor or medical geneticist who can provide such counseling services. All my questions have been answered, and I have had the necessary time to make an informed decision about the genetic test(s).

I hereby give permission to Baylor Genetics to conduct genetic testing as recommended by my physician*.

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

 _____ / _____ / _____
 Patient's Parent / Personal Representative* Name Patient's Parent / Personal Representative Signature Date Signed (MM / DD / YYYY)

*If you are signing on behalf of the patient as the parent(s) and/or person with legal authority to act on behalf of the patient or parent, you may be required to provide evidence of your authority.