

# TEST REQUISITION FORM

SPECIMEN COLLECTION DATE & TIME (REQUIRED)

## 1. LABORATORY TEST(S) ORDERED (COMPLETE SECTIONS 1, 2, 3 & 4)

- SensiGene™ Cystic Fibrosis Carrier Screening Test** Diagnosis/ICD9 Code(s) Required: \_\_\_\_\_
- SensiGene™ Fetal RHD Genotyping Test and Fetal Sex Determination** Diagnosis/ICD9 Code(s) Required: \_\_\_\_\_
- Other \_\_\_\_\_ Diagnosis/ICD9 Code(s) Required: \_\_\_\_\_

**FOR FETAL SEX TEST WITHOUT RHD, COMPLETE SECTIONS 2, 3 & 5**

## 2. ORDERING PHYSICIAN

Sequenom CMM Lab Acct#		
ACCOUNT NAME	NPI#	
(Last, First)		
ORDERING PHYSICIAN		
ADDRESS		
CITY	STATE	ZIP
OFFICE CONTACT		
PHONE #	FAX #	

## INFORMED CONSENT

I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given informed consent for the test(s) to be performed. I confirm that the person listed as the Ordering Physician is authorized by law to order the test(s) requested herein.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Required in AK, AR, FL, GA, MA, MI, NE, NY, NM, SC, SD, VT

## 3. PATIENT INFORMATION

NAME	SS#	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	____/____/____
(LAST, FIRST, INITIAL)			(MM/DD/YYYY)	
ADDRESS	CITY	STATE	ZIP	PHONE

### ANCESTRY

- Caucasian/White  Ashkenazi Jewish  Asian  Native American/American Indian
- African American/Black  Sephardic Jewish  Hispanic  Other \_\_\_\_\_

### CLINICAL INFORMATION (complete all that apply)

Is patient pregnant?  No  Yes If yes, complete the following: # Fetuses (circle one): 1 2 >2  
 U/S date: \_\_\_\_/\_\_\_\_/\_\_\_\_ GA on U/S date: \_\_\_\_wks \_\_\_\_days  
 LMP date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Maternal Blood Type: A  B  AB  O  Estimated Date of Delivery \_\_\_\_\_

### TEST INDICATIONS (check all that apply)

- Carrier Screening, No Family History
- Family History of CF Relationship to Patient: \_\_\_\_\_
- Previous Affected Pregnancy (please specify): \_\_\_\_\_ Carrier \_\_\_\_\_ Affected Mutation(s) Identified in Family: \_\_\_\_\_
- Maternal Blood Type Rh Negative Maternal RhD Status  +  -
- Other (please specify): \_\_\_\_\_

## 4. BILLING/PAYMENT INFORMATION

### OPTION 1: PATIENT INSURANCE (Requires copy of insurance card and patient/insured signature)

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insurance ID#/SS#: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patient Relationship to Insured: \_\_\_ self \_\_\_ spouse \_\_\_ child \_\_\_ other Authorization/Referral #: \_\_\_\_\_

I hereby authorize Sequenom Center for Molecular Medicine (Sequenom CMM Lab) to furnish my designated insurance carrier, health plan or third party administrator the information on this form and other information provided by my health care provider if necessary for reimbursement. I also authorize all benefits of the plan to be payable to Sequenom CMM Lab. I understand that I am responsible for any amount not paid by my Plan for reasons including, but not limited to non-covered or non-authorized services.

Patient/Insured Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### OPTION 2: PATIENT PAYMENT (Please call Customer Service at 1-877-821-7266 (SCMM) for questions regarding test prices)

- Please bill my credit card in the amount of \$ \_\_\_\_\_. Card # \_\_\_\_\_ Exp. Date: \_\_\_\_\_
- VISA  MasterCard  American Express
- Cardholder Name (please print) \_\_\_\_\_ Cardholder Signature: \_\_\_\_\_
- Personal check, cashier's check or money order enclosed; payable to Sequenom Center for Molecular Medicine, LLC.

### OPTION 3: Client Bill

## 5. SENSIGENE™ Fetal<sup>XY</sup> TEST

### SensiGene™ Fetal<sup>XY</sup> Test (Fetal Sex Determination)

### OPTION 1: PATIENT PAYMENT (Please call Customer Service at 1-877-821-7266 (SCMM) for questions regarding test prices)

- Please bill my credit card in the amount of \$ \_\_\_\_\_. Card # \_\_\_\_\_ Exp. Date: \_\_\_\_\_
- VISA  MasterCard  American Express
- Cardholder Name (please print) \_\_\_\_\_ Cardholder Signature: \_\_\_\_\_
- Personal check, cashier's check or money order enclosed; payable to Sequenom Center for Molecular Medicine, LLC.

### OPTION 2: Client Bill

Patient Name: \_\_\_\_\_  
 Patient DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
 Patient DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
 Patient DOB: \_\_\_\_\_