BAYLOR GENETICS

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
GRAND BLVD. RECEIVING DOCK
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

GENEAWARE REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

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

Address | City | State | Zip | Phone

Accession # | Hospital / Medical Record #

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**

☐ 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)

Patient's Relationship to Insured | Phone of Insured

Address of Insured

City | State | Zip

Primary Insurance Co. Name | Primary Insurance Co. Phone

Primary Member Policy # | Primary Member Group #

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

Patient's Relationship to Insured | Phone of Insured

Address of Insured

City | State | Zip

Secondary Insurance Co. Name | Secondary Insurance Co. Phone

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)

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

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

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

SAMPLE TYPE

- ◯ Blood (Collected in 4 cc EDTA tube with GeneAware barcode)*
- ◯ Saliva (Collected in GeneAware kit)
- ◯ Buccal Swab (Collected in GeneAware kit)

INDICATION FOR CARRIER TESTING (REQUIRED)

- ◯ No Family History
- ◯ Patient Known Carrier *
- ◯ Partner Known Carrier *
- ◯ Known Family History * (Specify relationship)
- ◯ Male Infertility / Female Infertility
- ◯ Family History of Consanguinity
- ◯ Egg / Sperm Donor
- ◯ Abnormal Fetal Ultrasound (Specify)

_____ _____

** Please provide the below information and attach report, if applicable.*

Disease

Gene | Variant

Is Patient or Patient's Partner Currently Pregnant?
Testing is not available to minors, unless pregnant. ◯ Yes ◯ No

If Yes, please specify Gestational Age:

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

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

Gestational Age on U/S Date: _____ Weeks _____ Days

ICD10 Diagnosis Code(s): _____

CARRIER TESTING PANELS

FEMALE | 64000

- ◯ Basic (6 genes)
- ◯ ACMG and ACOG (24 genes)
- ◯ Ashkenazi Jewish (39 genes)
- ◯ Complete (158 genes)

MALE | 64005

- ◯ Basic (6 genes)
- ◯ ACMG and ACOG (24 genes)
- ◯ Ashkenazi Jewish (37 genes)
- ◯ Complete (158 genes)

MERGED COUPLE REPORTS FOR GENEAWARE PANELS

NOTE: If an individual's sample is submitted after their partner's sample has already been submitted, and the couple wishes to have a merged report, both results will be held until all testing is completed in order to produce a merged report. This may cause the couple's merged report to be sent out longer than 14 days from the first sample submitted, but within 14 days of the second sample submitted.

Partner Last Name | Partner First Name

MI | Date of Birth (MM / DD / YYYY)

- ◯ Couple Sent Together
- ◯ Partner Sent Previously

Baylor Lab # | Family #

By agreeing to this informed consent, you provide authorization for your results to be disclosed to your ordering physician and other covered entities. If both you and your partner are being tested simultaneously or if your results are subsequently merged, you are authorizing the release of your results to your partner's healthcare provider, which may include sensitive medical information. Your results may become part of your partner's medical record, which is available to your partner's physician and other covered entities.

IF NOT SIGNED, SEPARATE REPORTS WILL BE ISSUED

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

Patient Signature | Date (MM / DD / YYYY)

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

Partner Signature | Date (MM / DD / YYYY)

NEW YORK STATE PHYSICIAN SIGNATURE OF CONSENT

I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested. I have answered this person's questions. I have obtained informed consent from the patient or their legal guardian for this testing.

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