

GENETIC CARRIER & PRENATAL SCREENING



FEMALE PATIENT MALE PATIENT

LAST NAME _____
FIRST NAME _____
PATIENT ID _____
DATE OF BIRTH (MM/DD/YYYY) _____ TELEPHONE NUMBER _____

Asian African American Hispanic
 Caucasian Jewish, Ashkenazi Other/Mixed/Unknown _____

EMAIL _____
STREET NUMBER _____ STREET NAME _____ APT NUMBER _____
CITY _____ STATE _____ ZIP _____

ACKNOWLEDGEMENT: I authorize the laboratory to provide to my health plan the information on this form and other information provided by my healthcare provider if necessary for reimbursement. I understand that the laboratory may seek prior authorization for testing from my health plan on my behalf. I also authorize all benefits of the plan to be payable directly to the laboratory, and I agree to remit to the laboratory any payment for these services made directly to me. I understand that the laboratory may be an out-of-network provider for my health plan and that I am responsible for all amounts not reimbursed by my health plan. I hereby designate the laboratory as my Authorized Representative, as provided under ERISA, 29 C.F.R. § 2560.5031 (b)(4), and/or as my Attorney in Fact, for the purpose of pursuing administrative appeals to which I am entitled and, if the laboratory deems it appropriate, any legal and/or equitable claims that I could bring against my health plan, and/or its fiduciaries, and/or its administrators, with respect to their handling or resolution of my insurance claim. I authorize information to be shared with my partner if also undergoing testing.

I authorize the laboratory to retain and use my de-identified specimen and test data (where all information that could link me to the specimen or data has been removed) for research and/or help develop new products or services, in compliance with applicable laws.

I do not authorize the laboratory to retain and use my de-identified specimen and test data as described above.

REQUIRED **PATIENT SIGNATURE** _____ DATE (MM/DD/YY) _____

REQUIRED **ORDERING CLINICIAN SIGNATURE** _____ DATE (MM/DD/YY) _____

PREGNANCY INFO – REQUIRED FOR FEMALE PATIENTS

Is female patient pregnant? NO Z31.430 YES (select box below and complete remaining fields)

First pregnancy (primigravida): 1st Tri Z34.01 2nd Tri Z34.02 3rd Tri Z34.03
Not first pregnancy (multigravida): 1st Tri Z34.81 2nd Tri Z34.82 3rd Tri Z34.83

GESTATIONAL AGE AT DRAW _____ EST. DATE OF DELIVERY (MM/DD/YY) _____ DATING METHOD _____
WEEKS _____ DAYS _____ LMP Ultrasound Other _____
 Singleton Twin Other _____ Unknown _____ PATIENT WEIGHT _____ PATIENT HEIGHT _____
 Egg donor pregnancy 009.811 AGE OF DONOR _____ LBS _____ FT _____ IN _____

CARRIER TESTING

AVERO CARRIER TEST For disorders tested, visit: averodx.com/performance

3901 **Trio Panel**^{1,2,3} CF, SMA, and FX 2004 **Cystic Fibrosis** 600 mutations
 3500 **Standard Panel**^{1,2,3} 29 disorders with ACOG/ACMG guidelines 2400 **Spinal Muscular Atrophy**
 3501 **Global Panel**^{1,2,3} 200+ disorders 2500 **Fragile X Syndrome**³
 3502 **Global+ Panel**^{1,2,3} 220+ disorders 3300 **Hemoglobin Evaluation** includes sickle cell (see description on reverse)

Other (All tests can be ordered individually.) _____

2201 ¹OPT IN for Tay-Sachs Hexosaminidase A enzyme analysis
 3800 ²OPT IN for Fetal Sex testing (gestational age 10 weeks or later)
 2502 ³OPT OUT of Xpansion Interpreter[®] for Fragile X results with 55 – 90 CGG repeats

CLINICAL INFO

REQUIRED - Is there a family history of genetic disorders? SPECIFY CONDITION: _____
 NO, and patient is female Z31.430
 NO, and patient is male Z31.440
 YES, Hereditary genetic disorder Z84.81
 YES, Musculoskeletal disorder Z82.69

RELATIONSHIP TO PATIENT OR PARTNER: _____

Patient has had a blood transfusion (past 3 months) or a bone marrow/organ transplant
 Patient has had previous carrier testing (attach report)

Is partner available for testing, if needed? YES NO

PARTNER'S DATE OF BIRTH (MM/DD/YYYY) _____ PARTNER'S NAME (OPTIONAL) _____

OTHER DIAGNOSIS (SPECIFY ICD-10) _____

Testing not available in New York State.

CLINICIAN INFO

REQUIRED **ORDERING CLINICIAN SIGNATURE** _____ DATE (MM/DD/YY) _____

ADDITIONAL REPORTS TO: CLINICIAN NAME _____

NPI# _____ FAX NUMBER _____

BILLING INFO

BILL INSURANCE Attach legible front and back copy of insurance cards.

INSURANCE COMPANY _____ IPA NAME _____
MEMBER ID _____ PRIOR AUTHORIZATION, IF NEEDED _____

BILL PATIENT The patient will be contacted to review payment options.
 BILL ORDERING CLINICIAN

SPECIMEN INFO

Collected on: _____ Time: _____ AM PM
Collected by: _____

Collection Requirement Key: See Specimen Guide for additional specimen types

- 4 mL Lavender-top EDTA tube
- 8.5 mL Yellow-top ACD tube
- 10 mL Streck DNA tube
- 4 mL serum separator tube (SST)

PRENATAL SCREENING

AVERO PRENATAL SCREEN Gestational age 10 weeks or later

2800 **Singleton Pregnancy** noninvasive screening for chromosomes 21, 18, 13, X and Y
 OPT OUT of screening for sex chromosome aneuploidies (no fetal sex information)

2800 **Twin Pregnancy** noninvasive screening for chromosomes 21, 18, 13, and Y
 OPT OUT of screening for Y chromosome (no fetal sex information)

CLINICAL INFO

Patient has had a blood transfusion (past 3 months) or a bone marrow/organ transplant

INCREASED RISK DUE TO:

Advanced Maternal Age (AMA):
 AMA first pregnancy (primigravida) – 1st Tri 009.511 Abnormal serum screening 028.1
 AMA first pregnancy (primigravida) – 2nd Tri 009.512 Ultrasound indicating structural anomaly 028.3
 AMA not first pregnancy (multigravida) – 1st Tri 009.521 Prior pregnancy w/aneuploidy Z82.8
 AMA not first pregnancy (multigravida) – 2nd Tri 009.522 Other (ICD-10) _____

MATERNAL SERUM SCREENING

Patient weight is required for all maternal serum screening tests.

2901 **First Trimester Screen** (PAPP-A, hCG)
Requires nuchal translucency ultrasound.
Gestational age 10 – 13 weeks 6 days
For twins, attach separate form: averodx.com/ultrasound

2902 **Second Trimester Quad Screen** (AFP, uE3, hCG, DIA)
Gestational age 15 – 22 weeks 6 days

2900 **Open Neural Tube Screen (AFP)**
Gestational age 15 – 22 weeks 6 days

ULTRASOUND INFORMATION

Ultrasound date _____
Crown rump length _____ mm (34.0 – 85.0)
Nuchal translucency _____ mm
Nasal Bone: Not evaluated Present Absent
Sonographer Name _____
Sonographer ID _____
Credentialed by NTQR FMF Other _____

CLINICAL INFO

Patient is an insulin-dependent diabetic Patient smokes cigarettes

OTHER DIAGNOSIS (SPECIFY ICD-10) _____

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NOTE: Carrier testing for X-linked disorders is not performed in males. Standard, Global, and Global+ panels include testing for CF, SMA, fragile X, Ashkenazi Jewish disorders, and a hemoglobin evaluation.

HEMOGLOBIN EVALUATION

Red blood cell count	Mean corpuscular volume (MCV)	Red cell distribution width (RDW)
Hemoglobin	Mean corpuscular hemoglobin (MCH)	Hemoglobin electrophoresis
Hematocrit		

CLINICAL INDICATIONS

GENETIC CARRIER SCREENING

Screening for other metabolic disorders	Z13.228
Nonprocreative screening for genetic disease carrier status	Z13.71
Female for testing for genetic disease carrier status for procreative management	Z31.430
Male for testing for genetic disease carrier status for procreative management.....	Z31.440
Supervision of normal first pregnancy, first trimester	Z34.01
Supervision of normal first pregnancy, second trimester	Z34.02
Supervision of normal first pregnancy, third trimester	Z34.03
Supervision of other normal pregnancy, first trimester	Z34.81
Supervision of other normal pregnancy, second trimester.....	Z34.82
Supervision of other normal pregnancy, third trimester.....	Z34.83
Supervision of normal pregnancy, unspecified, first trimester	Z34.91
Supervision of normal pregnancy, unspecified, second trimester.....	Z34.92
Supervision of normal pregnancy, unspecified, third trimester.....	Z34.93
Family history of intellectual disabilities	Z81.0
Family history of other diseases of the musculoskeletal system and connective tissue	Z82.69
Family history of carrier of genetic disease	Z84.81

PRENATAL ANEUPLOIDY SCREENING

Supervision of pregnancy with history of infertility, first trimester	009.01
Supervision of pregnancy with history of infertility, second trimester	009.02
Supervision of pregnancy with other poor reproductive or obstetric history, first trimester	009.291
Supervision of pregnancy with other poor reproductive or obstetric history, second trimester	009.292
Supervision of elderly primigravida, first trimester	009.511
Supervision of elderly primigravida, second trimester	009.512
Supervision of elderly primigravida, third trimester	009.513
Supervision of elderly multigravida, first trimester	009.521
Supervision of elderly multigravida, second trimester	009.522
Supervision of elderly multigravida, third trimester	009.523
Supervision of pregnancy resulting from assisted reproductive technology, first trimester	009.811
Supervision of pregnancy resulting from assisted reproductive technology, second trimester	009.812
Supervision of pregnancy resulting from assisted reproductive technology, third trimester	009.813
Supervision of other high risk pregnancies, first trimester	009.891
Supervision of other high risk pregnancies, second trimester	009.892
Supervision of other high risk pregnancies, third trimester	009.893
Abnormal hematological finding on antenatal screening of mother	O28.0
Abnormal biochemical finding on antenatal screening of mother	O28.1
Abnormal cytological finding on antenatal screening of mother	O28.2
Abnormal ultrasonic finding on antenatal screening of mother	O28.3
Abnormal radiological finding on antenatal screening of mother	O28.4
Abnormal chromosomal and genetic finding on antenatal screening of mother	O28.5
Other abnormal findings on antenatal screening of mother	O28.8
Unspecified abnormal findings on antenatal screening of mother	O28.9
Maternal care for (suspected) chromosomal abnormality in fetus, not applicable or unspecified	O35.1XX0
Maternal care for (suspected) hereditary disease in fetus, not applicable or unspecified	O35.2XX0
Other screening for genetic and chromosomal anomalies	Z13.79
Family history of other disabilities and chronic diseases leading to disablement, not elsewhere classified	Z82.8