GENETIC CARRIER & PRENATAL SCREENING

AVERO™

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 X | 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** WEEKS DAYS | EST. DATE OF DELIVERY (MM/DD/YY) | DATING METHOD ☐ LMP ☐ Ultrasound ☐ Other

☐ Singleton ☐ Twin ☐ Other _____ ☐ Unknown | PATIENT WEIGHT LBS | PATIENT HEIGHT FT IN

☐ Egg donor pregnancy 009.811 AGE OF DONOR

CARRIER TESTING

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

☐ 5050 5060 **Standard** 25 genes with ACOG/ACMG guidelines

☐ 5030 5040 **Trio** CF, SMA, and FX

☐ 5010 5020 **Exon** 150+ genes

☐ 5064 5068 **Global** 280+ genes

☐ **Other** (All tests can be ordered individually.) _____

CLINICAL INFO

REQUIRED - Is there a family history of genetic disorders?

☐ 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

SPECIFY CONDITION:

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

ACKNOWLEDGEMENT: I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given consent as required under applicable laws and regulations for the test(s) to be performed. The patient has completed pre-testing genetic counseling. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purposes for this patient. I confirm that the person listed as the Ordering Clinician is authorized by law to order the tests(s) requested herein.

REQUIRED ORDERING CLINICIAN SIGNATURE X | 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 | 4 mL serum separator tube (SST) | 10 mL Streck DNA tube

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 O09.511
☐ AMA first pregnancy (primigravida) – 2nd Tri O09.512
☐ AMA not first pregnancy (multigravida) – 1st Tri O09.521
☐ AMA not first pregnancy (multigravida) – 2nd Tri O09.522

☐ Abnormal serum screening O28.1
☐ Ultrasound indicating structural anomaly O28.3
☐ Prior pregnancy w/aneuploidy Z82.8
☐ Other (ICD-10) _____

MATERNAL SERUM SCREENING

Patient weight is required for all maternal serum screening tests.

☐ 2901 **First Trimester Screen** (PAPP-A, hCG)
Gestational age 10 – 13 weeks 6 days
Requires nuchal translucency ultrasound.
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)

PATIENT NAME _____ DATE OF BIRTH _____

PATIENT NAME _____ DATE OF BIRTH _____

PATIENT NAME _____ DATE OF BIRTH _____

PATIENT NAME _____ DATE OF BIRTH _____

NOTE: Carrier testing for X-linked disorders is not performed in males.

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	O09.01
Supervision of pregnancy with history of infertility, second trimester	O09.02
Supervision of pregnancy with other poor reproductive or obstetric history, first trimester	O09.291
Supervision of pregnancy with other poor reproductive or obstetric history, second trimester	O09.292
Supervision of elderly primigravida, first trimester	O09.511
Supervision of elderly primigravida, second trimester	O09.512
Supervision of elderly primigravida, third trimester	O09.513
Supervision of elderly multigravida, first trimester	O09.521
Supervision of elderly multigravida, second trimester	O09.522
Supervision of elderly multigravida, third trimester	O09.523
Supervision of pregnancy resulting from assisted reproductive technology, first trimester	O09.811
Supervision of pregnancy resulting from assisted reproductive technology, second trimester	O09.812
Supervision of pregnancy resulting from assisted reproductive technology, third trimester	O09.813
Supervision of other high risk pregnancies, first trimester	O09.891
Supervision of other high risk pregnancies, second trimester	O09.892
Supervision of other high risk pregnancies, third trimester	O09.893
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