evolve®
LEADERS IN GENETIC FERTILITY SCREENING™

General Requisition Form International

1 PATIENT INFORMATION

Last Name ____ First Name ____

Date of Birth (mm/dd/yyyy) ____ ❑ M ❑ F Sex Telephone/Fax ____

Email Address ____

Address ____ Country ____

ETHNICITY (check all that apply)

❑ French Canadian ❑ African-American ❑ Asian ❑ Jewish-Ashkenazi
❑ Jewish-Sephardic ❑ East Indian ❑ Native American ❑ Hispanic
❑ Mediterranean ❑ Caucasian/NW European ❑ Other ____

CLINICAL INFORMATION (check all that apply)

❑ Patient has had transfusion within the past 30 days ❑ Patient has had bone marrow transplant
❑ Patient or family member is pregnant LMP/EDD ____
❑ Results will directly impact patient treatment ❑ Family history of genetic disease
❑ IVF surrogate ❑ Egg Donation ❑ Other IVF procedures
❑ Multiple gestation ❑ Surrogate mother
FAMILY HISTORY INFORMATION (List any specific disorders or conditions)

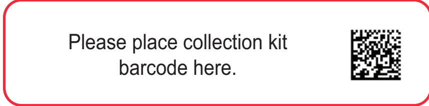
Patient Acknowledgment

PLEASE SIGN BELOW AFTER READING THE PATIENT INFORMED CONSENT TERMS AT www.EvolveGene.com/informedconsent

By signing this Requisition Form, I, the patient having the screening performed, acknowledge and agree that (i) I have been offered the opportunity to ask questions and discuss with my healthcare provider the benefits, risks and limitations of the screen to be performed; (ii) I have discussed with the healthcare provider ordering this screen the reliability of positive and negative screening results and the level of certainty that a positive screening result for a given disease or condition serves as a predictor of that disease or condition; (iii) I have been informed of the availability and importance of genetic counseling and have been provided with information regarding how I may obtain such genetic counseling; (iv) I have read and understood the Informed Consent at www.EvolveGene.com and agree to its terms, and I understand that they are also available at www.EvolveGene.com, and that I may retain a printed copy for my records; (v) I consent to the use of the leftover specimen and health information as described in the Patient Informed Consent; (vi) I consent to having this screen performed, and I will discuss the results and appropriate medical management with my healthcare provider; (vii) I will be responsible for the full cost of this screen.

X ____ Patient's Signature ____ Date

2 SPECIMEN INFORMATION



Collection Date: (mm/dd/yyyy) ____ Time Collected ____ ❑ AM ❑ PM

Specimen Type ❑ SALIVA ❑ BLOOD

Specimen Tube ❑ SALIVA
❑ BLOOD – Lavendar Top (EDTA)
❑ BLOOD – Green Top (NaHep)

3 ORDERING CLINICIAN INFORMATION

Organization ____ Account # ____

Email Address ____ Telephone/Fax ____

Ordering Clinician (Last, First) ____

Address ____ Country ____

CLINICIAN SIGNATURE OF CONSENT REQUIRED BELOW

I hereby order Evolve to conduct the requested tests, which I have determined to be medically necessary. I have explained genetic testing (including the risks, benefits, and alternatives) to this individual. I have addressed the limitations outlined in the informed consent form, and I have answered this person's questions to the best of my ability.

X ____ Signature ____ Date

If you want the results of this case to be sent to an additional fax or email, please indicate.

____ Fax/Email

4 ORDERING INFORMATION

FERTILITY GENETIC SCREENS
❑ Male FertilityReady™
❑ Female FertilityReady™
❑ POF FertilityReady™

CARRIER GENETIC SCREENS
❑ FamilyReady™
❑ j-FamilyReady™

SPECIALTY GENETIC SCREENS
❑ TRIO (Cystic Fibrosis, Spinal Muscular Atrophy, Fragile X Syndrome)
❑ TRIO+ (CF, SMA, Fragile X, ACOG Recommended Disorders)
❑ Fragile X Syndrome: FMR1 CGG Repeat Analysis
❑ Fragile X Syndrome: Optional Reflex FMR1 AGG Interruptions
❑ Cystic Fibrosis
❑ Spinal Muscular Atrophy
❑ Alpha-Thalassemia
❑ Beta-Thalassemia/Sickle Cell Disease
❑ Disorders of Sexual Development Panel

❑ Pituitary Hormone Deficiency Panel
❑ Zellweger Syndrome Panel
❑ Custom ____

5 PAYMENT INFORMATION

❑ **BILL CLINIC**
❑ **SELF PAY**

Credit Card Number ____ Name of Card holder ____

Expiry Date (mm/yy) ____ ❑ VISA ❑ MC ❑ AMEX ❑ DISCOVER

Contact us for other payment methods.

FINAL CHECK LIST FOR EACH SAMPLE SHIPPED:

☑ Is the Ordering Physician provided along with signature?
☑ Are all Clinical Information questions answered?
☑ Did you include two patient identifiers on the specimen tube label?
☑ Did you provide the Date of Sample Collection?

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