EarlyPregnancy™ (NIPT) Prenatal Screen Requisition Form – International

evolve®
LEADERS IN GENETIC FERTILITY SCREENING™

1 PATIENT INFORMATION

Last Name _____ First Name _____

Date of Birth (mm/dd/yyyy) _____ ☐ M ☐ F Sex _____ Telephone/Fax _____

Email Address _____

Address _____ Country _____

Gestational age _____ # of weeks _____ # of days _____ Date (mm/dd/yyyy)

Dating method: ☐ LMP ☐ CRL ☐ Date of implantation ☐ Other _____

Maternal weight _____ (lbs/kg) height _____ (in/cm)

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 ☐ Pedigree ☐ Other _____
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

Please place collection kit barcode here.

Collection Date: (mm/dd/yyyy) _____ Time Collected _____ ☐ AM ☐ PM

Specimen Tube ☐ BLOOD – Black/Tan Top

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

Choose either test (EarlyPregnancy™ or EarlyPregnancy™ Plus) and all options that apply.

EARLYPREGNANCY™ (CHROMOSOMES 21, 18, 13)

☐ Singleton

Additional Option:
☐ XY determination and sex chromosome aneuploidies

☐ Twin

Additional Option:
☐ Presence of Y chromosome

OR

EARLYPREGNANCY™ PLUS (CHROMOSOMES 21, 18, 13)

Singleton

Additional options:

☐ **Option A: Microdeletions**
[(22q11 deletion (DiGeorge); 15q11 deletion (Angelman/Prader-Willi); 1p36 deletion; 4p- (Wolf-Hirschhorn); 5p- (Cri-du-chat)]
☐ **include XY determination and sex chromosome aneuploidies**

☐ **Option B*: All Chromosomes (including sex chromosome aneuploidies)**
[*additional fees]

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?
- ☑ Did you provide gestational age?
- ☑ 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?

EvolveGene • 12105 28th Street, Suite A, Saint Petersburg, FL 33716 • www.EvolveGene.com
Support@EvolveGene.com • Canada/US: 1-800-963-3203 • Intl.: 001-519-763-2720