evolve®
LEADERS IN GENETIC FERTILITY SCREENING™

General Requisition Form

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

Please place collection kit barcode here.

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) _____ NPI _____

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 _____

Enter ICD-10 Diagnosis Codes:

_____
_____
_____

Refer to reverse side for ICD-10 Codes

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.

☐ **BILL INSURANCE**

Policy Holder Name (if different from patient) _____

Insurance Carrier _____

Insurance ID _____ Group No. _____

ENCLOSE A PHOTOCOPY (FRONT & BACK) OF ALL RELEVANT INSURANCE CARDS + DRIVER'S LICENSE (PATIENT DEMOGRAPHICS SHEET)

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

General Requisition Form

ICD-10 CODES

Male Infertility, unspecified	N46.9
Female infertility, unspecified	N97.9
Encounter for screening for other metabolic disorders	Z13.228
Nonprocreative screening for genetic disease carrier status	Z13.71
Other screening for genetic and chromosomal anomalies	Z13.79
Screening for other disorder	Z13.89
Genetic Susceptibility to Genetic Disease because of High Risk Ethnicity.	Z15.89
Encounter for fertility testing	Z31.41
Encounter of female for testing for genetic disease carrier status for procreative management	Z31.430
Encounter for other genetic testing of female for procreative management	Z31.438
Encounter of male for testing for genetic disease carrier status for procreative management	Z31.440
Encounter for other genetic testing of male for procreative management	Z31.448
Procreative Management Testing	Z31.49
Supervision of normal first pregnancy; 1st trimester	Z34.01
Supervision of normal first pregnancy; 2nd trimester	Z34.02
Supervision of normal first pregnancy; 3rd trimester	Z34.03
Supervision of other normal pregnancy, 1st trimester	Z34.81
Supervision of other normal pregnancy, 2nd trimester	Z34.82
Supervision of other normal pregnancy, 3rd trimester	Z34.83
Encounter for supervision of normal pregnancy, unspecified, first trimester	Z34.91
Encounter for supervision of normal pregnancy, unspecified, second trimester	Z34.92
Encounter for supervision of normal pregnancy, unspecified, third trimester	Z34.93
Family history of intellectual disabilities	Z81.0
Family history of carrier of genetic disease	Z84.81
Family history of other specified conditions	Z84.89

The ICD-10-CM diagnosis codes listed above are commonly associated with genetic screening. This list is intended for reference only, please refer to the ICD-10-CM manual for a complete listing. The ultimate responsibility for correct coding belongs to the ordering physician. EvolveGene makes no recommendation regarding the use of any particular diagnosis code(s). Diagnosis information should be reflected in the patient's medical record.

FINAL CHECK LIST FOR EACH SAMPLE SHIPPED:

- ☑ Is the Ordering Physician provided along with signature?
- ☑ Did you include copies of both sides of the insurance card?
- ☑ Is an ICD-10 code(s) provided?
- ☑ 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