evolve®
LEADERS IN GENETIC FERTILITY SCREENING™

EarlyPregnancy™ (NIPT) Prenatal Screen Requisition Form

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) _____ 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

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]

Enter ICD-10 Diagnosis Codes:

_____

_____

Refer to reverse side for additional 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)

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ICD-10 CODES FOR FETAL ANEUPLOIDY NONINVASIVE PRENATAL 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 pregnancy with other poor reproductive or obstetric history, third trimester	O09.293
Supervision of pregnancy with other poor reproductive or obstetric history, unspecified trimester	O09.299
Supervision 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 primigravida, unspecified trimester	O09.519
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 elderly multigravida, unspecified trimester	O09.529
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
Supervision of other high risk pregnancies, unspecified trimester	O09.899
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, fetus 1	O35.1XX1
Maternal care for (suspected) chromosomal abnormality in fetus, fetus 1	O35.1XX1
Maternal care for (suspected) chromosomal abnormality in fetus, fetus 2	O35.1XX2
Maternal care for (suspected) chromosomal abnormality in fetus, fetus 2	O35.1XX2
Maternal care for (suspected) hereditary disease in fetus, fetus 1	O35.2XX1
Maternal care for (suspected) hereditary disease in fetus, fetus 2	O35.2XX2
Maternal care for other (suspected) fetal abnormality and damage, fetus 1	O35.8XX1
Maternal care for other (suspected) fetal abnormality and damage, fetus 2	O35.8XX2
Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 1	O35.9XX1
Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 2	O35.9XX2
Other specified trisomies and partial trisomies of autosomes	Q92.8
Balanced translocation and insertion in normal individual	Q95.0
Encounter for other screening for genetic and chromosomal anomalies	Z13.79
Encounter for other genetic testing of female for procreative management	Z31.438
Encounter for antenatal screening of mother	Z36
Family history of other disabilities and chronic diseases leading to disablement, not elsewhere classified	Z82.8

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?
- ☑ 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?

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