

## COMPARATOR SAMPLE FORM

PERSON COMPLETING FORM	CONTACT (DIRECT PHONE OR EMAIL)	DATE OF REQUEST (MM/DD/YYYY)
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### COMPARATOR INFORMATION

LAST (FAMILY) NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YYYY)
ADDRESS	CITY	STATE/PROVIDENCE	ZIP / POSTAL CODE
EMAIL	PHONE NUMBER	GEOANCESTRY / ETHNICITY	
MEDICAL RECORD NUMBER (MRN)	BIOLOGICAL SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other, specify karyotype _____		
RELATIONSHIP TO PROBAND / PATIENT	ONGOING PREGNANCY <input type="checkbox"/> NO <input type="checkbox"/> YES	For testing on a prenatal specimen from an ongoing pregnancy complete the Prenatal Test Requisition Form.	
HAS PATIENT BEEN TESTED PREVIOUSLY AT PreventionGenetics? <input type="checkbox"/> No <input type="checkbox"/> Yes, PG ID# _____	BLOOD TRANSFUSION <input type="checkbox"/> NO <input type="checkbox"/> Within last 6 weeks, include date and type DATE (MM/DD/YYYY) _____ TYPE _____	BONE MARROW TRANSPLANT <input type="checkbox"/> NO <input type="checkbox"/> Yes, include date DATE (MM/DD/YYYY) _____	
ICD-10 CODES (REQUIRED FOR INSURANCE BILLING) 1 PRIMARY _____ 2 _____ 3 _____			

**RELEVANT CLINICAL INFORMATION.** We require the inclusion of detailed clinical notes/completion of the **clinical features checklist** and a pedigree. The ability to interpret variants directly correlates with the quality of clinical information provided. ☐ Clinical records attached.

- ☐ Affected  
☐ Unaffected

### SPECIMEN INFORMATION

<b>SPECIMEN SOURCE</b> <input type="checkbox"/> Whole Blood <input type="checkbox"/> Direct CVS <input type="checkbox"/> Saliva <input type="checkbox"/> Direct Amniotic Fluid <input type="checkbox"/> Buccal <input type="checkbox"/> Cultured Cells, Source _____	<input type="checkbox"/> Tissue, Source _____ <input type="checkbox"/> Extracted DNA, Source _____ <input type="checkbox"/> Other _____	<b>SPECIMEN COLLECTION DATE</b> (MM/DD/YYYY)  If no collection date is provided, date of receipt will be used.	<input type="checkbox"/> <b>SPECIMEN COLLECTED IN NEW YORK STATE</b> Include New York State Genetic Testing Healthcare Provider Statement and New York State Non-Permitted Laboratory Test Request approval letter if test is not NY state approved. For a list of NY state approved tests, see <a href="#">website</a> .
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### PROBAND INFORMATION

LAST (FAMILY) NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YYYY)
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### COMPARATOR TEST SELECTION

For Family - Duo or Trio, testing will be held up to 3 weeks waiting for family member specimens. Provide information below if there is an extenuating circumstance. Please submit a separate completed diagnostic or health screen test requisition to request a full analysis of the comparator data for an additional charge if desired. T

**ORDER OPTION** ☐ Positive Control ☐ Comparator for duo, trio, or quad proband analysis.  
☐ Include family/comparator demographics (name, DOB, ID#, and relationship) on the proband report.

COMMENTS

### PROVIDER / LABORATORY CONTACT

INSTITUTION				
ADDRESS		CITY	STATE	ZIP
REQUESTING PHYSICIAN (First, Last, Degree)		REQUESTING GENETIC COUNSELOR OR ALLIED PROVIDER (First, Last, Degree)		
EMAIL ADDRESS (For report access via myPrevent)		EMAIL ADDRESS (For report access via myPrevent)		
PHONE NUMBER	NPI# (US only)	PHONE NUMBER	NPI# (US only)	