PREVENTION GENETICS part of EXACT SCIENCES

Test information is available on our website:
PreventionGenetics.com

PREVENTIONGENETICS USE ONLY

RESET FORM

All testing must be ordered by a qualified Healthcare Provider

A completed online order **OR** paper TRF and labeled specimen is required to initiate testing.

COMPARATOR SAMPLE FORM

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

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

☐ Male ☐ Female ☐ Other, specify karyotype _____

RELATIONSHIP TO PROBAND / PATIENT

ONGOING PREGNANCY ☐ NO ☐ YES

For testing on a prenatal specimen from an ongoing pregnancy complete the Prenatal Test Requisition Form.

HAS PATIENT BEEN TESTED PREVIOUSLY AT PreventionGenetics?

☐ No

☐ Yes, PG ID# _____

BLOOD TRANSFUSION

☐ NO ☐ Within last 6 weeks, include date and type

DATE (MM/DD/YYYY) _____ **TYPE** _____

BONE MARROW TRANSPLANT

☐ NO ☐ 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

SPECIMEN SOURCE

☐ Whole Blood ☐ Direct CVS ☐ Tissue, Source _____

☐ Saliva ☐ Direct Amniotic Fluid ☐ Extracted DNA, Source _____

☐ Buccal ☐ Cultured Cells, Source _____ ☐ Other _____

SPECIMEN COLLECTION DATE (MM/DD/YYYY)

If no collection date is provided, date of receipt will be used.

☐ **SPECIMEN COLLECTED IN NEW YORK STATE**

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 website.

PROBAND INFORMATION

LAST (FAMILY) NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YYYY)

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)