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Clinical Questionnaire for **Reveal® SNP Microarray - Prenatal & POC**

This form should be completed when Reveal SNP Microarray – Prenatal or POC is ordered. The form should be completed by the ordering physician's office and should accompany the specimen. Please call 800-345-GENE (4363) with any questions and ask to speak to a cytogenetics genetic counselor.

Patient's name: _____ Date of birth: _____

Name of person completing form: _____

Specimen Type: ❍ Amniotic fluid ❍ Chorionic villi ❍ POC ❍ Prenatal fetal blood ❍ Postnatal cord blood

Fetal Sex: ❍ Male ❍ Female ❍ Unknown / **Method** (eg, ultrasound, NIPT, chromosomes): _____

Primary indication: _____ Gestational age: _____

G___P___ ___ ___ ___ Is this a twin/multiples pregnancy? ❍ **Yes** ❍ **No** If yes, check one: ❍ MZ ❍ DZ ❍ Unknown

Was pregnancy achieved through ART? If so, how: ❍ **Egg donor** ❍ **Sperm donor** ❍ **Self-donor** ❍ **Other donor** ❍ **IVF** ❍ **ICSI**

Was preimplantation genetic testing (PGT) performed? ❍ **Yes** ❍ **No**

Ultrasound Abnormalities (if abnormal, please check and describe the abnormality in the space provided)

❍ Head _____	❍ Heart _____	❍ Extremities _____
❍ Brain _____	❍ Abdominal wall _____	❍ Skeleton _____
❍ Face _____	❍ GI-tract _____	❍ Amniotic fluid _____
❍ Spine _____	❍ Kidneys _____	❍ Cord _____
❍ Neck/Skin _____	❍ Bladder _____	❍ Fetal growth _____
❍ Thorax _____	❍ Genitalia _____	❍ Movement _____

If other ultrasound abnormality, please describe: _____

Significant Patient History

Medications/Exposures: ❍ Yes ❍ No If yes, please describe: _____

Maternal illness/Infection: ❍ Yes ❍ No If yes, please describe: _____

Abnormal maternal serum screening: ❍ Yes ❍ No If yes, indicate results: _____

Abnormal NIPT results: ❍ Yes ❍ No If yes, indicate results: _____

Previous Genetic Test Results (if known — karyotype, microarray, sequencing, exome, etc)

Current pregnancy: _____ Date performed: _____ Lab: _____

Previous pregnancy: _____ Date performed: _____ Lab: _____

Parental chromosomes: Maternal _____ Date performed: _____ Lab: _____

Paternal _____ Date performed: _____ Lab: _____

Significant Family History

❍ Unknown or limited family history? Please explain (eg, adopted) _____

Relative*	**Maternal / Paternal**	**Condition/Clinical Diagnosis/Previous Genetic Test Results**	**Has genetic testing been performed?** If yes, attach lab report.
	❑ / ❑		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No

Ordering provider understands by signing below:
Pretest counseling, which includes an interpretation of family and medical histories; education about inheritance, genetic testing, disease management, prevention, and resources; counseling to promote informed choices and adaptation to the risk or presence of a genetic condition; and counseling for the psychological aspects of genetic testing, has been completed where required by health plan. Post-test counseling will be available.

Account No.: _____

Provider Name (print): _____ NPI: _____

Provider Phone No.: _____ Fax No.: _____

_____ / _____
Ordering Provider Signature **Date**

Patient understands by signing below:
LabCorp may use information obtained on this form and other information provided by me and/or my ordering provider or his/her designee to initiate prior authorization with my health plan as required. I understand a prior authorization approval from my health plan does not guarantee full payment. It is my responsibility to contact my health plan regarding concerns over my coverage and benefits.

_____
Patient Signature

_____
Date

LabCorp
www.LabCorp.com

*Relationships to consider include parents, siblings, offspring (1st degree), half-brothers/sisters, aunts/uncles, grandparents, grandchildren, nieces/nephews (2nd degree); first cousins, great-aunts/uncles, great-grandchildren, great grandparents (3rd degree).

Additional copies of this form can be printed from our website: www.integratedgenetics.com.

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LabCorp Specialty Testing Group