LCA Use Only.
Please place accessioning sticker here.

Clinical Questionnaire for Inheritest® Carrier Screen and GeneSeq® PLUS

Prior authorization questions, call **(866) 248-1265.** / Fax **(833) 421-0376** / Test questions, call **(800) 848-4436.**

Name and title of person completing this form _____

Patient Information

First Name: _____ Last Name: _____ Date of Birth: _____

Indication for Testing and Relevant Patient/Partner History (to be completed by the provider)

Select at least one:
- ◯ Genetic counseling performed by board-certified genetic counselor or clinical geneticist. If marked, attach genetic counseling report.
- ◯ Pretest counseling performed by ordering provider or designee in accordance with health plan policies.

Patient Ethnicity:
◯ African American ◯ Ashkenazi Jewish ◯ Asian American ◯ Caucasian
◯ Hispanic ◯ Jewish, non-Ashkenazi ◯ Other (specify) _____

Mark All That Apply

- ◯ Patient/partner is currently pregnant or is considering a pregnancy. If pregnant, specify gestational age: _____weeks _____ days
- ◯ Patient had previous carrier screening. If marked, are screening results available? ◯ Yes ◯ No
- ◯ Patient has unknown or limited family history (e.g. adopted). Please specify: _____
- ◯ Patient has no known or suspected family history of CF, SMA, or fragile X
- ◯ Patient is a known carrier of the fragile X premutation, intermediate, or full mutation
- ◯ Partner has known diagnosis of congenital absence of the vas deferens
- ◯ Patient and partner are consanguineous (related by blood)
- ◯ Partner has a diagnosis of CF or SMA. Please specify:_____
- ◯ Biological relative has diagnosis of CF, SMA, or fragile X. Specify disease and relationship of the individual to the patient (e.g. brother, sister, niece, first cousin, second cousin, etc): _____
- ◯ Partner of a known mutation carrier. Please specify genetic disorder and mutation:_____
- ◯ Biological relative is a known mutation carrier. Specify mutation and relationship of the individual to the patient (e.g. brother, sister, niece, first cousin, second cousin, etc): _____
  Are testing results available? ◯ Yes ◯ No
- ◯ History of unexplained intellectual disability or developmental delay, or autism in the patient or a blood relative
- ◯ Personal history of premature ovarian insufficiency or failure, premature menopause, or infertility associated with elevated FSH levels before the age of 40 with no known cause
- ◯ Family history of fragile X syndrome, fragile X-associated primary ovarian insufficiency, or fragile X-associated tremor/ataxia syndrome
- ◯ History of late onset intention tremor and cerebellar ataxia of unknown origin

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.

_____
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

This is not an order for a test.

Please include this form with sample and order for testing.

labcorp

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