LCA Use Only.
Please place accessioning sticker here.

# Clinical Questionnaire for **Inheritest® NGS**

**Please include this form with sample and order for testing.**

**Prior authorization questions, call 866-248-1265. / Fax 858-242-1710.**

**Name of person completing this form** _____

**Title of person completing this form** _____

## **Testing Information** (THIS IS NOT AN ORDER FOR A TEST)

### Carrier Screening Panels

| | | | | | |
|---|---|---|---|---|---|
| ❍ | 451950 | Inheritest® Comprehensive Panel, NGS | ❍ | 630049 | Inheritest® 500 PLUS Panel |
| ❍ | 451960 | Inheritest® Ashkenazi Jewish Panel, NGS | ❍ | 630217 | Inheritest® 500 PLUS with Repro Partners Report |
| ❍ | 451920 | Inheritest® Society-guided Panel, NGS | ❍ | Other: | |

## **Patient Demographics**

**Patient's name** _____ **Date of birth** _____

## **Patient History** (Please answer all * questions)

***1. Is the patient or partner currently pregnant?** ❍ Yes ❍ No If so, please provide gestational age: _____weeks _____days

***2. Is the patient or partner considering pregnancy?** ❍ Yes ❍ No

***3. Patient Ethnicity:** ❍ African American ❍ Ashkenazi Jewish ❍ Asian ❍ Caucasian ❍ Hispanic
❍ Native American ❍ Sephardic Jewish ❍ Other (specify) _____

***4. Is there a family history of genetic disease?** ❍ Yes ❍ No If so, which disease?
Affected individual's relationship to patient?

***5. Is there a family history of intellectual disability or autism?** ❍ Yes ❍ No
If so, please specify and provide the affected individual's relationship to patient?

***6. Is the patient adopted?** ❍ Yes ❍ No

***7. Is there a known consanguinity in the family?** ❍ Yes ❍ No

**8. Please provide any other indication for testing:**

**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 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**

Integrated GENETICS
LabCorp Specialty Testing Group

LabCorp CMBP: TIN: 13-3757370 / NPI: 1750368700
Integrated Genetics: TIN: 27-3267315 / NPI: 1689975021
MNG: TIN: 47-3459045 / NPI: 1447436514