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
❍	451920	Inheritest® Ashkenazi Jewish Panel, NGS	❍	630217	Inheritest® 500 PLUS with Repro Partners Report
❍	451960	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