**Labcorp Use Only.** Please place accessioning sticker here.

# Clinical Questionnaire for Reveal® SNP Microarray - Pediatric & Adult

Prior authorization questions, call **866-248-1265.** / Fax **336-436-1007** / Test questions, call **800-345-4363.**
Email: **PriorAuthEscalations@Labcorp.com**

Name and title of person completing this form _____

## Test Information (this is not an order for a test)

| **Note:** For Medicare recipients, a signed ABN must accompany the sample if an ICD-10 Code that supports medical necessity is not provided. | | | | | | |
|---|---|---|---|---|---|---|
| ICD-10 Diagnosis Code(s) **Required** | | | | | | |

| Test No. | Test Name |
|---|---|
| | |

## Patient Demographics

Patient's name _____ / Date of birth_____ / Sex: ◯ Male ◯ Female

Patient/guardian phone no. _____ / Patient/guardian email _____

## Patient History

**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. Post-test counseling will be available.

Development (any delays): _____

Cognitive: _____ ◯ Suspect autism spectrum disorder

Motor (gross): _____(fine motor): _____

Growth (delays/overgrowth, etc): _____

Other: _____

**Any dysmorphic features** (unusual facial characteristics): _____

## Review of Systems (please comment on any issues/problems/abnormal studies associated with each system)

Neurological/Mental: _____

Chest/Lungs: _____

Heart: _____

Genital/Urinary: _____

Skeletal/Limbs: _____

Eyes/Skin: _____

Other: _____

## Prenatal History

Any signficant prenatal history: _____

Abnormal labs: _____

Chromosome analysis results: _____ Year performed _____

## 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 |

**Genetic Counseling—Ordering provider understands by signing below:**
If genetic counseling by a board-certified genetic counselor is required by the health plan prior to laboratory testing but has not occurred as indicated in the Patient History section above, I understand that a referral may be made by the laboratory to a board-certified genetic counselor required or authorized by the health plan.
**Such referral is solely related to laboratory testing and does not relieve me of any obligation to seek authorization for my services.**

**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 their 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**

*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).

TIN: 13-3757370 / NPI: 1750368700

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