LCA Use Only.
Please place accessioning sticker here.

Clinical Questionnaire for **Noninvasive Prenatal Testing (NIPT)**

Please include this form with sample and order for testing.

Prior authorization questions, call 866-248-1265. / Fax 336-436-1007.

Name of person completing this form _____

Title _____ **Phone number** _____

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

MaterniT Test Options

❍	451927	MaterniT21 PLUS Core
❍	451937	MaterniT21 PLUS Core + ESS + SCA
❍	451934	MaterniT21 PLUS Core + SCA
❍	451931	MaterniT21 PLUS Core + ESS
❍	451941	MaterniT Genome

MaterniT Test Options (No Gender)

❍	451951	MaterniT21 PLUS Core, No Gender
❍	452122	MaterniT21 PLUS Core + ESS + SCA, No Gender
❍	452112	MaterniT21 PLUS Core + SCA, No Gender
❍	452136	MaterniT21 PLUS Core + ESS, No Gender
❍	452106	MaterniT Genome, No Gender

Patient Demographics

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

Patient History (Please answer all numbered questions)

1. Gestational age: _____weeks _____days | **2. Number of fetuses:** _____

3. Egg donor was used: ❍ Yes ❍ No | **4. Has patient already had cell-free DNA testing with current pregnancy?** ❍ Yes ❍ No

5. Please indicate reason(s) for testing (check all that apply):

- ❍ 35 years or older at the time of delivery
- ❍ History of prior pregnancy with a trisomy
- ❍ Positive first-trimester or second-trimester standard biomarker screening test
- ❍ Either parent has balanced Robertsonian translocation with an increased risk of fetal trisomy 13 or trisomy 21
- ❍ Ultra sonographic findings indicate an increased risk of aneuploidy

  Findings: _____
- ❍ Average risk pregnancy
- ❍ Other (please explain): _____

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

Integrated GENETICS
LabCorp Specialty Testing Group

TIN: 13-3757370 / NPI: 1750368700