BAYLOR GENETICS
READY WITH ANSWERS

SHIPPING Baylor Genetics
2450 Holcombe Blvd., Grand Blvd. Receiving Dock
Houston, TX 77021-2024
Phone: 713.798.6555
Fax: 713.798.2787

PRESEEK NON-INVASIVE PRENATAL SCREENING REQUISITION

DEMOGRAPHIC INFORMATION

Maternal Last Name | Maternal First Name | MI | Maternal Date of Birth (MM/DD/YY)

Address | Accession # | Hospital/ Medical Record #

Biological Sex: ◯ M ◯ F ◯ Unknown

City | State | Zip | Phone

Gender identity (if different from above):

REPORTING RECIPIENTS

Ordering Physician | Institution Name

Email (Required for International Clients) | Phone | Fax

◆ **ADDITIONAL RECIPIENTS**

Name | Name

Email | Fax | Email | Fax

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

Testing will not be held for verification of payment. Do not submit specimen until payment type is confirmed.

☐ **SELF PAYMENT**

◯ Bill Patient For Laboratory Testing ◯ Bill to patient's credit card (complete Credit Card Payment Authorization found at bmgl.com and send with requisition)

☐ **INSTITUTIONAL BILLING**

Institution Name | Institution Code | Institution Contact Name | Institution Phone | Institution Contact Email

☐ **INSURANCE**

REQUIRED ITEMS: Copy of the Front/Back of Insurance Card(s), ICD10 Diagnosis Code(s), Name of Ordering Physician, Insured Signature of Authorization

Name of Insured | Insured Date of Birth (MM/DD/YY) | Address of Insured

Patient's Relationship to Insured | Phone of Insured | City | State | Zip

Primary Insurance Co. Name | Primary Insurance Co. Phone | Primary Member Policy # | Primary Member Group #

Secondary Insurance Co. Name | Secondary Insurance Co. Phone | Secondary Member Policy # | Secondary Member Group #

By signing below, I hereby authorize Baylor Genetics to provide my designated insurance carrier any information necessary, including test results, for processing my insurance claim. I also authorize benefits to be payable exclusively to Baylor Genetics. I understand that my insurance carrier may not approve or reimburse my medical genetic services in full or any portion thereof, due to a variety of reasons, including, but not limited to: the contract status of my insurance provider with Baylor Genetics, usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates. I understand that I am responsible for any amounts not paid by my insurance carrier for reasons including, but not limited to,non-covered and non-authorized services. I understand that I am responsible for sending Baylor Genetics any and all payments that I receive directly from my insurance company in payment for this test. I am aware that Medicare does not cover routine screening tests. I understand that my insurance company may not pay for this procedure as being medically necessary or a covered benefit. If denied for one of these reasons, I agree to be responsible for the self-pay price of PreSeek.

Maternal Patient's Name | Maternal Patient's Signature | Date

STATEMENT OF MEDICAL NECESSITY (REQUIRED)

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Physician's Printed Name | Physician's Signature | Date

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IMPORTANT NOTES

- Both biological parental samples are REQUIRED for PreSeek testing to be performed. Paternal sample must be from the biological father. There is no charge for the paternal sample.
- If a sample from the biological father is unavailable, PreSeek testing cannot be performed.
- PreSeek can only be performed on singleton pregnancies. Furthermore, PreSeek cannot be performed on pregnancies in which there has been a fetal demise, vanishing twin, or reduction.
- If pregnancy was achieved using an egg donor, we will require the following samples 1) blood in a Streck tube from the woman carrying the pregnancy 2) blood in an EDTA tube or saliva from the biological father AND 3) blood in an EDTA tube or saliva from the egg donor. There is no charge for the egg donor sample.

MATERNAL SPECIMEN INFORMATION

Maternal Last Name _____ Maternal First Name _____ MI _____ Maternal Date of Birth (MM/DD/YY) ____/____/____

◆ **TEST OPTION**

☐ 21200 - PreSeek (Maternal)

◆ **CLINICAL FINDINGS**

	Primigravida	Multigravida
☐ Advanced Maternal Age: 35+ years (at delivery) for singleton pregnancies	◯ O09.511 (1st Tri)	◯ O09.521 (1st Tri)
	◯ O09.512 (2nd Tri)	◯ O09.522 (2nd Tri)
	◯ O09.513 (3rd Tri)	◯ O09.523 (3rd Tri)

☐ Advanced Paternal Age

☐ Abnormal Serum Biochemical Screening: ◯ O28.1 ◯ Other: _____

☐ Ultrasound Finding (Attach Report and Specify): ◯ O35.1XX0

☐ Maternal - Personal or Family History of a genetic disorder (Specify):

☐ Paternal - Personal or Family History of a genetic disorder (Specify):

☐ Abnormal NIPT (Specify ICD-10 Code): _____

◯ TRI 21 ◯ TRI 18 ◯ TRI 13 ◯ Other: _____

	Primigravida	Multigravida
☐ Low Risk Pregnancy/ Parental Concern:	◯ Z34.00	◯ Z34.80

☐ Other (Specify ICD-10 Code): _____

◆ **SAMPLE**

____/____/____ Date of Collection (MM/DD/YY)

We recommend that the sample is received in the lab within 72 hours after collection. Samples received in the lab greater than 5 days after date of collection will be rejected.

◆ **SAMPLE TYPE ***

◉ Streck Tube Number of Streck Tubes: ____

Sample requirement is 2 Streck tubes, each with a minimum of 8mL of blood

◆ **GESTATIONAL INFORMATION (REQUIRED)**

Patient must be at least 10 weeks gestation at the time of blood draw.

_____ ◯ ft/in ◯ cm Maternal Height

_____ ◯ lbs ◯ kgs Maternal Weight

Gestational Age on Date of Collection: ____ Weeks ____ Days

Dating Method: ◯ LMP ____/____/____ MM DD YY

◯ U/S ____/____/____ MM DD YY

Was egg donor used? ◯ YES ◯ NO

If yes, a blood sample from the egg donor is required. Complete the egg donor section on pg 3

Was sperm donor used? ◯ YES ◯ NO

If yes, sperm donor is the biological father. Please complete section below.

PATERNAL SPECIMEN INFORMATION

Paternal Last Name _____ Paternal First Name _____ MI _____ Paternal Date of Birth (MM/DD/YY) ____/____/____

◆ **TEST OPTION**

☐ 21203 - PreSeek (Paternal) - WILL NOT BE BILLED

◯ Paternal sample to be sent later. (Lab policy requires paternal sample to be received within 5 days of maternal sample)

◆ **SAMPLE**

____/____/____ Date of Collection (MM/DD/YY)

◆ **SAMPLE TYPE ***

◯ Saliva ◯ Blood in EDTA

Please send either blood or saliva for the paternal sample.

* Refer to Sample Specifications Table (page 3)

FOR SAMPLES SUBMITTED FROM NEW YORK STATE

_____ Maternal Initial _____ Paternal Initial

Specimen Retention: My sample shall be destroyed at the end of the testing process or not more than 60 days after completion of testing. However, I hereby authorize the lab to retain my sample(s) for a longer retention in accordance to the laboratory retention policy for internal laboratory quality assurance studies and possible research testing.

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PRESEEK NON-INVASIVE PRENATAL SCREENING REQUISITION

EGG DONOR INFORMATION (IF APPLICABLE)

Egg Donor Last Name or ID _____ Egg Donor First Name or ID _____ MI _____ Egg Donor Date of Birth (MM/DD/YY) ___/___/___

◆ **TEST OPTION**

☐ 21203 - PreSeek (Egg Donor) - WILL NOT BE BILLED

◆ **SAMPLE**

___/___/___ Date of Collection (MM/DD/YY)

◆ **SAMPLE TYPE ***

◯ Saliva ◯ Blood in EDTA

* Refer to Sample Specifications Table (page 3)

ETHNICITIES

◆ **BIOLOGICAL MATERNAL ETHNICITY**

◯ African American
◯ Ashkenazi Jewish
◯ East Asian (China, Japan, Korea)
◯ Finnish
◯ French Canadian
◯ Hispanic American
◯ Mennonite
◯ Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey)
◯ Native American
◯ Northern European Caucasian (Scandinavian, UK, Germany)
◯ Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia)
◯ South Asian (India, Pakistan)
◯ Southeast Asian (Vietnam, Cambodia, Thailand)
◯ Southern European Caucasian (Spain, Italy, Greece)
◯ Other (Specify) _____

◆ **BIOLOGICAL PATERNAL ETHNICITY**

◯ African American
◯ Ashkenazi Jewish
◯ East Asian (China, Japan, Korea)
◯ Finnish
◯ French Canadian
◯ Hispanic American
◯ Mennonite
◯ Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey)
◯ Native American
◯ Northern European Caucasian (Scandinavian, UK, Germany)
◯ Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia)
◯ South Asian (India, Pakistan)
◯ Southeast Asian (Vietnam, Cambodia, Thailand)
◯ Southern European Caucasian (Spain, Italy, Greece)
◯ Other (Specify) _____

SAMPLE SPECIFICATIONS TABLE

PATIENT	ABBREVIATION	SAMPLE NAME	RECOMMENDED AMOUNT	SHIPPING INSTRUCTIONS	SPECIAL NOTES
Paternal / Egg Donor	BE	Blood in EDTA tube (purple-top)	3 - 5 cc	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	
Paternal / Egg Donor	SA	Saliva	See Special Notes	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	Collected with Oragene DNA Self-Collection Kit.
Maternal	ST	Streck Tube	Two 10mL tubes	Ship at room temperature in an insulated container by overnight courier. Do not heat or freeze.	We recommend that the sample is received in the lab within 72 hours after collection. Samples received in the lab greater than 5 days after date of collection will be rejected.

SAMPLE ICD-10 DIAGNOSIS CODES

The ICD-10 diagnosis code(s) must be defined for the most detailed level of specificity available. The following list of commonly used ICD-10 codes for prenatal testing is not complete. Please refer to the ICD-10 manual for a complete listing. These codes are being provided for informational purposes only; it is ultimately the responsibility of the ordering provider to select the appropriate ICD-10 code supported by the patient's medical record.

Advanced Maternal Age: Primigravida [O09.511(1st trimester); O09.512(2nd trimester); O09.513(3rd trimester); O09.519 (Unspecified trimester)]
Advanced Maternal Age: Multigravida [O09.521(1st trimester); O09.522(2nd trimester); O09.523(3rd trimester); O09.529 (Unspecified trimester)]
Abnormal Serum Biochemical Screen: O28.1
Ultrasound Finding: O35.1XX0; O28.3, O28.4, O35.9XX0, O35.9XX1, O35.9XX9
Positive Test Result for Aneuploidy: O28.5, O28.8, O28.9, O35.1XX1, O35.1XX9
Personal Family History:
Prior pregnancy with trisomy [O09.291(1st trimester); O09.292(2nd trimester); O09.293(3rd trimester); O09.299 (Unspecified trimester)]
Other High Risk Pregnancies [O09.891 (1st trimester); O09.892 (2nd trimester); O09.893 (3rd trimester); O09.899 (Unspecified trimester)]
Robertsonian translocation [Q95.0 (Balanced Translocation) Q95.1 (Chromosome Inversion)]

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GENES ANALYZED ON PRESEEK

GENE	DISORDER
Craniosynostosis Syndromes	
FGFR2	Antley-Bixler syndrome without genital anomalies or disordered steroidogenesis, Apert syndrome, Crouzon syndrome, Jackson-Weiss syndrome, Pfeiffer syndrome type 1/2/3
Noonan Spectrum Disorders	
BRAF	Cardiofaciocutaneous syndrome 1
CBL	Noonan syndrome-like disorder with or without juvenile myelomonocytic leukemia (NSLL)
HRAS	Costello syndrome/Noonan syndrome
KRAS	Noonan syndrome/cancers
MAP2K1	Cardiofaciocutaneous syndrome 3
MAP2K2	Cardiofaciocutaneous syndrome 4
NRAS	Noonan syndrome 6/cancers
PTPN11	Noonan syndrome 1/LEOPARD syndrome/cancers
RAF1	Noonan syndrome 5/LEOPARD syndrome 2
RIT1	Noonan syndrome 8
SHOC2	Noonan syndrome-like disorder with loose anagen hair
SOS1	Noonan syndrome 4
SOS2	Noonan syndrome 9

GENE	DISORDER
Skeletal Disorders	
FGFR3	Achondroplasia, CATSHL syndrome, Crouzon syndrome with acanthosis nigricans, Hypochondroplasia, Muenke syndrome, Thanatophoric dysplasia, types I and II
COL1A1	Ehlers-Danlos syndrome, classic and type VIIA, Osteogenesis imperfecta, types I, II, III, and IV
COL1A2	Ehlers-Danlos syndrome, cardiac valvular form and type VIIB, Osteogenesis imperfecta, types II, III, and IV
Syndromic Disorders	
JAG1	Alagille syndrome
CHD7	CHARGE syndrome
HDAC8	Cornelia de Lange syndrome 5
NIPBL	Cornelia de Lange syndrome 1
RAD21	Cornelia de Lange syndrome 4
SMC1A	Cornelia de Lange syndrome 2
SMC3	Cornelia de Lange syndrome 3
TSC1	Tuberous sclerosis 1
TSC2	Tuberous sclerosis 2
CDKL5	Epileptic encephalopathy, early infantile, 2
MECP2	Rett syndrome
NSD1	Sotos syndrome 1
SYNGAP1	Intellectual disability, type 5

CONSENT FOR TESTING

PreSeek is a cell-free fetal DNA noninvasive prenatal screen that analyzes fetal disorders in maternal blood. PreSeek screens for genetic disorders that can cause skeletal dysplasias, cardiac defects, multiple congenital anomalies and/or intellectual defects due to variants in the genes included (see list). Both biological parental samples are required for this test; the test cannot be performed without samples from both biological parents. This test is not appropriate for individuals who had a blood transfusion in the last month or a bone marrow transplant.

PreSeek will report only pathogenic and likely pathogenic variants and will not report variants of uncertain significance or benign variants. PreSeek detects predominantly de novo variants (a gene variant that is present in the fetus but not the biological parents) which occur with increasing frequency as paternal age advances. However, this testing may possibly indicate that a parent of the fetus has or is predisposed to one of these genetic disorders tested. PreSeek does not screen for fetal chromosome aneuploidies or other copy number abnormalities.

PreSeek should be ordered by a healthcare provider who should provide appropriate genetic counseling to the patient prior to ordering the test and after receiving results. Positive screening results should always be followed-up with an invasive, diagnostic test before any medical decisions are made.

I understand that:
1) If the PreSeek results are positive, I should consult my physician or genetic counselor and consider further invasive fetal testing.
2) The PreSeek results may inform me of a pathogenic or likely pathogenic variant that is present in only myself or my partner, but may not be present in the fetus. This information is important for me to understand the complete risk for this pregnancy. I understand that a negative PreSeek result does not rule out the possibility of the fetus, myself, or my partner of having a genetic disorder.
3) It is possible that additional information may come to light during these studies regarding family relationships. For example, data may suggest that family relationships are not as reported, such as misattributed parentage (e.g. maternal/paternal identity is different than indicated on the requisition). Variant interpretation is based on the family relationship information provided to Baylor Genetics by the ordering healthcare provider.
4) The information obtained from the PreSeek test may be used in scientific publications or presentations, but my specific identity will not be revealed in such publications/ presentations. Baylor Genetics may reach out to my healthcare provider to obtain more information regarding the outcome of my pregnancy over the next one to two years.

All specimens will be retained in the laboratory in accordance with the laboratory retention policy and, if from New York State, will be discarded within 60 days.

Maternal Patient's Name	Maternal Patient's Signature	Date
Paternal Patient's Name	Paternal Patient's Signature	Date
Egg Donor Patient's Name (if applicable)	Egg Donor Patient's Signature (if applicable)	Date (if applicable)