INVITAE

ORDER ID
For internal use only

INVITAE REQUISITION FORM

PATIENT INFORMATION

First name	MI	Last name	Date of birth (MM/DD/YYYY)

Sex assigned at birth
◯ Male ◯ Female

Gender (if differs from sex assigned at birth)
◯ Man ◯ Non-binary ◯ Woman ◯ Self-described: _____

Race/Ethnicity (select all that apply):
◯ Ashkenazi Jewish ◯ Asian ◯ Black ◯ French Canadian ◯ Hispanic ◯ Native American ◯ Pacific Islander ◯ Sephardic Jewish ◯ White ◯ Other: _____

Patient ID (MRN)	Email address (billing and report access after clinician releases)	Mobile Phone (patient consents to receive texts from the laboratory)

Address	City	State/Prov	Zip/Postal code	Country

Ship a saliva kit to this patient (optional)
◯ Ship kit to address above ◯ Ship kit to alternate address: _____

PROVIDER INFORMATION

Organization name	Phone	Fax

Address	City	State/Prov	Zip/Postal code	Country

Primary clinical contact name (if different from ordering provider)

Name	NPI	Email address (for report access)

Ordering provider (Pre-populate your provider list below. For each order, indicate **one** ordering provider by marking the checkbox before the name)

	Name	NPI	Email address (for report access)
◯			
◯			
◯			
◯			
◯			
◯			

Additional clinical or laboratory contacts (optional)

◯ Share this order with the primary clinical contact's default clinical team (manage team online at invitae.com/signin)

Name	Email address (for report access)	Name	Email address (for report access)
Name	Email address (for report access)	Name	Email address (for report access)

◯ INSURANCE BILLING

Provide only if applicable. Attach front and back of insurance card, clinical notes and medical records. Insurance is not accepted for patients outside the US invitae.com/billing

Policyholder name	Patient relationship to policyholder ◯ Self ◯ Spouse ◯ Child ◯ Other: _____		
Primary insurance company name	Primary member ID#	Primary insurance phone	Prior-authorization #
Secondary insurance company name	Secondary member ID#	Secondary insurance phone	Prior-authorization #

Medicare insurance billing only (select one): ◯ Patient was treated as a hospital inpatient (more than a 24 hour stay) in the last 14 days ◯ Not a hospital patient

◯ SELF-PAY BILLING

We will send an electronic invoice to the patient email listed above. Insurance will not be billed.

◯ INSTITUTIONAL BILLING

We will send an invoice to the organization address above. Please contact us if this order should be billed to a different location.

◯ PARTNERSHIP PROGRAMS

Invitae partner code:

WITHIN THE US | p: 800-436-3037 | f: 415-276-4164 | e: clientservices@invitae.com | OUTSIDE THE US | p: +1 415-930-4018 | f: +1 510-417-3922 | e: globalsupport@invitae.com
1400 16th Street, San Francisco, CA 94103, USA | invitae.com/contact |

INVITAE

Patient's first name

Patient's last name

INVITAE REQUISITION FORM

SPECIMEN INFORMATION

Label each tube with the patient's full name, date of birth, and specimen collection date. A requisition form MUST accompany each specimen.

Collection date (MM/DD/YYYY)

For DNA, provide date retrieved from archive.

Specimen type

◯ Blood ◯ Saliva ◯ DNA - source: _____

*We cannot accept blood or oral specimens from patients with active hematologic malignancy, recent leukocyte transfusion, or history of bone marrow/stem cell/liver transplants. DNA must be extracted in a CLIA or other suitably certified lab and cannot be from prenatal or tumor sources. Details at: **invitae.com/specimen-requirements***

Specimen ID (IB # on tube):

Is this patient deceased? ◯ Yes ◯ No

Deceased date (MM/DD/YYYY)

REASON FOR TESTING

Primary indication:

ONCOLOGY

◯ Hereditary breast and ovarian cancer (HBOC) syndrome
◯ Lynch syndrome
◯ Polyposis (FAP)
◯ Other: _____

CARDIOLOGY

◯ Aortopathy
◯ Cardiomyopathy
◯ Arrhythmia
◯ Other: _____

OTHER

◯ Neurology
◯ Other: _____

ICD-10 codes (required for insurance billing)

PERSONAL HISTORY

Is/was this patient affected or symptomatic†? ◯ Yes ◯ No If yes, describe below and attach clinical notes.

Age at diagnosis: _____

†Symptomatic means the patient has features or signs known or suspected to be related to the genetic testing being ordered and could include findings on physical examination, laboratory tests, or imaging.

Is there a hematological malignancy in this patient (current or history of)? ◯ Yes ◯ No

Has this patient had genetic testing before? ◯ Yes ◯ No If yes, write test results and attach the report.

FAMILY HISTORY

Is there a family history of disease for which the patient is being tested? ◯ Yes ◯ No

If yes, describe below and attach pedigree and/or clinical notes.

Relationship to patient	Maternal or paternal	Diagnosed condition	Age at diagnosis

TEST SELECTION

OPTION 1: SELECT AN INVITAE PANEL FROM OUR TEST CATALOG

Select your desired test(s) from the attached test catalog and discard any pages without a selection.

OPTION 2: INVITAE TEST CODE

Indicate test IDs here (reference **invitae.com/tests** or our test catalog). Test IDs containing add-on codes will include the original panel as well as the add-on.

Test code	Add-on code (optional)	Test code	Add-on code (optional)

OR

To create a custom panel, log in to your Invitae portal account or contact Client Services. Then indicate the ID associated with that panel here.

Custom panel ID

OPTION 3: FAMILY FOLLOW-UP TESTING

Invitae family follow-up testing is available at no additional charge for blood relatives of patients who receive pathogenic or likely pathogenic results (or approved VUS). Learn more at **invitae.com/family**.

Invitae proband RQ# _____

Relationship to proband _____

Gene(s) _____

Variant(s) _____

Invitae family follow-up testing analyzes the variant(s) indicated above. If you would like this report to include any variants of uncertain significance and be eligible for re-requisition, please include billing information on this requisition form and check here: ☐

AUTOMATIC REFLEX: One re-requisition is offered at no additional charge for tests within the same clinical area (**invitae.com/re-requisition**). Preschedule it here or in your Invitae portal.

Conditions for reflex: ◯ Regardless of initial results ◯ Only if negative (no pathogenic/likely pathogenic results)

Reflex test: **Test code** _____ . **Add-on code (optional)**

Invitae is now part of Labcorp Genetics. By signing this form, I acknowledge that the patient (or the individual authorized to make decisions for the patient) has been supplied information regarding and consented to undergo genetic testing, as set forth in Labcorp Genetics' Informed Consent for Genetic Testing (**invitae.com/forms**). I acknowledge that the patient has agreed that (1) for orders originating outside the US, the patient's personal information and specimen will be transferred to and processed in the US (2) Labcorp Genetics may notify the patient of clinical updates related to genetic test results (in consultation with the ordering provider) (3) Labcorp Genetics and its designees may release information concerning testing to the patient's insurer (if billing to insurance) (4) the patient is responsible for any amount the insurer does not pay or pays directly to the patient and the patient has agreed to make or pass through such payment for services rendered. I attest that I am authorized under applicable law to order this test. If required by the patient's insurer, I attest that I offered pre-test genetic counseling to the patient or authorized Labcorp Genetics to assist the patient in obtaining pre-test genetic counseling from a third party. I agree to the transfer of information from this TRF to a letter of medical necessity and/or other documentation using my name as the signature. For US ordering providers only: I consent and direct Labcorp Genetics to share my contact information with third parties who may contact me directly in connection with patient results (opt out via online portal). For California providers only: I have the right to opt-out of certain uses of my data, and additional rights as detailed in Labcorp Genetics' privacy policy (**invitae.com/privacy/privacy-policy**). For Montana providers only: I agree to keep on file and make available to Labcorp Genetics, upon request, a copy of the consent form signed by the patient. If I am a delegate, I confirm I have authorization to (1) agree to all of the above and (2) sign this form and any supporting documents on behalf of the ordering provider.

Medical professional or delegate signature (required)	Date (MM/DD/YYYY)

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