INVITAE

ORDER ONLINE at www.invitae.com/signin.

ORDER ID
For Invitae internal use only

INVITAE REQUISITION FORM

PATIENT INFORMATION

First name: Margene | MI: | Last name: Terence | Date of birth (MM/DD/YYYY): 06 08 1983

Biological sex: (○) Male (●) Female

MRN (medical record number):

Ancestry: (●) Asian (○) Black/African American (○) White/Caucasian (○) Ashkenazi Jewish (○) Hispanic (○) Native American (○) Pacific Islander (○) French Canadian (○) Sephardic Jewish (○) Mediterranean (○) Other: _____

Email address (for billing contact and report access after clinician releases): MargeneTerence@email.com

Mobile phone (for billing contact):

Address:

City: | State/Prov: | Zip/Postal code: | Country: USA

Ship a saliva kit to this patient (to submit this request, fax this completed requisition form to Invitae Client Services at 415-276-4164)

(○) Ship kit to address above (○) Ship kit to alternate address: _____

CLINICAL INFORMATION

Organization name	Phone	Fax
Chicago - New User Location	1234567890	0987654321

Address	City	State/Prov	ZIP/Postal Code	Country
515 N StateSt Teststreet	Chicago	Illinois	60005	USA

CLINICAL TEAM

Primary clinical contact (contact for general inquires)

Name	NPI	Email address (for report access)
CIQ Email		ciqappemail@gmail.com

Ordering provider (●) Same as primary clinical contact

For your convenience, we have provided multiple fields below to pre-populate your organization's provider list. For each order, indicate one ordering provider.

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

Additional clinical or laboratory contacts (optional; share online access to this order with the contacts below)

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

Name	Email address (for report access)	Name	Email address (for report access)
CIQ Email	ciqappemail@gmail.com		

INSURANCE BILLING (attach front and back of insurance card)

Attach clinical notes, medical records, and/or letter of medical necessity (LMN) to prevent delays. We do not accept insurance for certain tests *or* patients outside the US. www.invitae.com/billing

Policyholder name	Patient relationship to policyholder		
Margene Terence	(○) 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

PATIENT PAY BILLING

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

INSTITUTIONAL BILLING

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

PARTNERSHIP PROGRAMS

Invitae partner code:

INVITAE

Patient's first name: Margene

Patient's last name: Terence

INVITAE DIAGNOSTIC 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. www.invitae.com/specimen-requirements

Collection date (MM/DD/YYYY): 11/26/2023

If not provided, date will be 1 day prior to our receipt of specimen. For DNA, provide date retrieved from archive.

Specimen type

○ Blood ○ Saliva ○ DNA - source: _____

DNA must be extracted in a CLIA or other suitably certified laboratory. We are unable to accept blood or saliva from patients with allogeneic bone marrow transplants or a blood transfusion <2 weeks prior to specimen collection.

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
Aunt	Maternal	Ovarian	45
Brother		Colon or Rectal	45

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 www.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)
01701			
01101			

OR

Invitae supports customization of your test. 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 www.invitae.com/family.

Invitae proband RQ# _____

Relationship to proband _____

Gene(s) _____

Variant(s) _____

Invitae's 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: Invitae offers one re-requisition at no additional charge for tests within the same clinical area (www.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)**

By signing this form, the medical professional acknowledges that the individual/ family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo genetic testing, substantially as set forth in Invitae's Informed Consent for Genetic Testing (www.invitae.com/forms). For orders originating outside the US, the Patient has been informed their personal information and specimen will be transferred to and processed in the US. The Patient has been informed that Invitae may notify them of clinical updates related to genetic test results (in consultation with the ordering medical professional). If insurance billing is selected, the Patient has further been informed and authorizes Invitae Corporation ("Invitae") and its designees to release information concerning testing to their insurer in order to process and/ or appeal claims. The medical professional agrees to allow Invitae to transfer the information from this requisition to a letter of medical necessity and/or other documentation using the medical professional's name as the signature. For amounts received directly, the Patient has agreed to remit payment to Invitae for testing services rendered. I acknowledge that the Patient has agreed that if the Patient's insurer does not reimburse Invitae in full for any reason, including if the insurer considers the genetic test ordered to be a non-covered service or not medically necessary, then Invitae may bill the Patient directly for the services and the Patient will remit payment directly to Invitae. I acknowledge that I offered pre-test genetic counseling to the Patient, if required by their insurer. I attest that I am authorized under applicable law to order this test.

Medical professional signature (required)

Date (MM/DD/YYYY): 11/26/2023

Family History of Cancer

Limited family structure (fewer than two 1st-or 2nd-degree female relatives surviving beyond 45 years of age in either lineage)

BROTHER:
Colon or Rectal, Age at Diagnosis: 45

MATERNAL AUNT:
Ovarian, Age at Diagnosis: 45

Personal History of Cancer & Other Clinical Information

- History of Colon Polyps: None
- Premm 5 Score: 2.22%
- Bone marrow transplant recipient: No
- Previous Genetic Testing: No