natera | Anora® Miscarriage test (POC)

123456-2-X

Please place collection kit barcode here.

PATIENT INFORMATION (FIELDS IN YELLOW OR GRAY ARE REQUIRED)

Patient Last Name | Patient First Name | Patient Email | Cell Phone

Date of Birth (MM/DD/YY) | Address | City | State | Zip

PATIENT ACKNOWLEDGEMENT: I have been informed of and understand the details of the test ordered herein for me by my health care provider, including the risks, benefits, and alternatives, and have consented to testing. I understand that the test results may inform me of a medical condition that may require medical follow-up. I also understand that a negative result does not rule out the possibility of such medical condition. I authorize Natera or other provider to share the information on this form and my test results with my insurer/health plan ("plan") on my behalf, with all benefits of my plan made payable directly to Natera or other provider. I understand that I am responsible for costs not paid by my plan directly to Natera for tests ordered, including, without limitation, any copayments, deductibles, or amounts deemed 'patient responsibility". I assign to Natera the right to appeal on my behalf negative coverage decisions made by my plan and to assert all rights and as the beneficiary thereof. I authorize Natera to charge my credit card for any balance I might owe with regard to my tests. The information obtained from my tests may be used in scientific research, publications or presentations, but my specific identity will not be revealed. Natera may contact my healthcare provider to obtain more information regarding clinical correlation and confirmatory testing. My leftover samples may be de-identified and used for research and development. I and my heirs will not receive payments, benefits, or rights to any resulting products or discoveries. If I do not want my samples used for research purposes, I will send a request in writing to Natera Sample Retention Department within 60 days after test results have been issued and my sample will be destroyed. New York residents must check this box ☐ and sign to the right to permit Natera to use their samples for research and development, otherwise the samples will be discarded within 60 days of testing. By providing the information included herein, I understand and agree I may be contacted via, e.g., e-mail, or cellular or home phone, by text message, automatic telephone dialing system, or computer assisted technology for treatment options, billing/collection matters, and health-related products, services, or studies. I understand that my treatment, payment, enrollment, or eligibility for benefits is not conditioned on my providing such consent, and I may opt out at any time or by checking this box ☐

Patient Signature | Date

PAYMENT INFORMATION

☐ Bill Insurance ☐ Bill Clinic ☐ Self Pay

Insurance Company | Group Number

Member Name | Member ID | Prior Authorization Number (If Applicable)

ORDERING CLINICIAN

LIMS 3964 Spectrum Health Referrals
Clinic or Organization

35 Michigan St. MC056, Grand Rapids, MI 49503
Address

(616) 267-2753
Telephone

616.267.2826
Fax

Ordering Clinician | Additional Report Recipient

CLINICIAN ACKNOWLEDGEMENT: I confirm the testing ordered herein is medically necessary and this patient has been informed of the details of the genetic test(s) ordered, including the risks, benefits, and alternatives, and has consented to testing as may be required by law, including NY CVR §79-I, as applicable.

Ordering Clinician / Authorized Signature

ANORA® TEST ORDERING (SEE DETAILS BELOW)

Sample Type: ☐ Fresh Sample ☐ Paraffin **– Pathology report required**

Please submit a parental blood sample. If egg donor was used, please submit sample from biological father. Both parental samples are needed for paraffin testing.

Sample Collection Date (MM/DD/YY) | Loss Date (MM/DD/YY) | Gestational Age at Loss (Weeks)

Name of Parent Providing Sample | Date of Birth (MM/DD/YYYY)

☐ Biological mother ☐ Biological father
☐ Gestational carrier/Egg donor recipient

Number of Prior Losses | Dates of Prior Losses (MM/DD/YY)

Pregnancy: ☐ Singleton ☐ Twin ☐ Triplet ☐ Other
If multiples: ☐ Identical ☐ Non-identical ☐ Unknown

Egg donor: ☐ Yes ☐ No

Surrogate: ☐ Yes ☐ No

Spectrum tested embryo: ☐ No ☐ Yes – Case/Embryo ID#

Clinical/Ultrasound findings: ☐ No ☐ Yes

Hospital/surgery center where Dilation & Curettage (D&C) was performed (if applicable)

Select applicable ICD-10 Code (REQUIRED):

- ☐ N96 Recurrent pregnancy loss
- ☐ O02.1 Missed abortion
- ☐ O02.0 Blighted ovum and nonhydatidiform mole
- ☐ O02.89 Other abnormal products of conception
- ☐ O02.9 Abnormal product of conception
- ☐ O36.4XX0 Maternal care for intrauterine death, not applicable or unspecified
- ☐ Z33.2 Encounter for elective termination of pregnancy

Other ICD-10 Code

ANORA TEST DESCRIPTIONS AND REQUIREMENTS (ANORA IS ONLY AVAILABLE FOR MISCARRIAGES AND/OR STILLBIRTHS)

FRESH SAMPLE

Sample Requirements:

Fetal Tissue: chorionic villi, gestational sac, fetal skin/tissue, umbilical cord tissue, cord blood, and/or cytogenetic tissue cell pellets. Must be received within 30 days of collection.

Parental Sample (suggested): One 6 mL Lavender-top K2 EDTA blood tube (minimum 2 mL required) or parental buccal swab (blood preferred). Must be received within 14 days of collection.

Submission Requirements:

1) Signed order form 2) Copy of insurance card

Test Description: Whole chromosome aneuploidy, Triploidy, Tetraploidy (3:1 only), Uniparental disomy (UPD) of a single chromosome pair, full/complete UPD, deletions and duplications greater than 5 Mb, clinically significant deletions and duplications greater than 1 Mb. One biological parent sample is required to detect maternal cell contamination, UPD, and parental origin of abnormalities.

PARAFFIN SAMPLE – Pathology report required

Sample Requirements:

Fetal Tissue: 10 serial slides: 1 H&E stained slide and 9 unstained slides OR formalin-fixed sample in a paraffin block.

Parental Samples (required): One 6 mL Lavender-top K2 EDTA blood tube (minimum 2 mL required) or buccal swab from BOTH biological parents (blood preferred). Must be received within 14 days of collection.

Submission Requirements:

1) Signed order form
2) Pathology report
3) Copy of insurance card

Test Description: Whole chromosome aneuploidy, Triploidy (paternal only), Tetraploidy (3:1 only), UPD of a single chromosome pair, full/complete UPD.

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