

Contract #:	LL: K254	MOHLTC Approval #:	
Ordering Physician Billing #:	Physician OHIP# (Ontario) Physician MSC# (British Columbia) Other Provinces: 999		LifeLabs Demographic Label
Ordering Physician:	Name		
Ordering Physician Address & Contact Information:	Tel: _____ Fax: _____		
Physician Signature			
Copy-to Client:	Name Tel: _____ Fax: _____		Counsyl Barcode Label
Bill to:	Bill type "C" (\$0) – (Counsyl: bill to MOHLTC)		

Patient Last Name:	Patient First Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: M M D D Y Y Y Y
Unit #:	Street:	City:	Prov.:
			Postal Code:
			Patient Telephone #: () -

PATIENT INFORMATION (REQUIRED)	Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for testing (select all that apply):	Ethnicity (select all that apply):
<input type="checkbox"/> Family history <input type="checkbox"/> Screening for genetic carrier status <input type="checkbox"/> Consanguinity <input type="checkbox"/> Supervision, normal 1st pregnancy <input type="checkbox"/> Supervision, other normal pregnancy <input type="checkbox"/> High risk ethnicity <input type="checkbox"/> Other: _____	<input type="checkbox"/> Northern European e.g. <i>British, German</i> <input type="checkbox"/> Southern European e.g. <i>Italian, Greek</i> <input type="checkbox"/> French Canadian or Acadian <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Other/Mixed Caucasian <input type="checkbox"/> East Asian e.g. <i>Chinese, Japanese</i> <input type="checkbox"/> South Asian e.g. <i>Indian, Pakistani</i> <input type="checkbox"/> Southeast Asian e.g. <i>Filipino, Vietnamese</i> <input type="checkbox"/> African or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Indigenous <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Unknown

TESTS REQUESTED			
Expanded Carrier Screen (Counsyl Foresight™)			LLTC
Carrier screening panel that performs sequencing of over 175 clinically significant conditions			5622
<input type="checkbox"/> FIRST TIME USER – please check this option if neither partner has been tested <input type="checkbox"/> PARTNER – please check this option if a previous sample has been submitted for your patient's partner			5623
Sample Type:	<input type="checkbox"/> Blood (EDTA: 4mL)	<input type="checkbox"/> Saliva (Oragene OG-510: Available by request)	
Date Sample Collected:	Time Sample Collected:	Collector Name:	
M M D D Y Y Y Y	H H M M		

PARTNER INFORMATION			
<i>* if your partner has already performed the Counsyl Expanded Carrier Screen</i>			
Partner Name:	Partner DOB:	M M D D Y Y Y Y	Partner Barcode #: From original report
	Date Partner tested:	M M D D Y Y Y Y	

**** PHOTOCOPY REQUISITION AND INCLUDE ORIGINAL WITH SAMPLE ****
 (Testing performed at Counsyl Inc., 180 Kimball Way South, San Francisco CA, 94080)

PATIENT CONSENT - MANDATORY:	
I have read and signed the Patient Consent Form, which is available at LifeLabsgenetics.com and remains with the ordering physician. I understand that 1 blood sample will be taken by LifeLabs staff. I acknowledge that my sample and personal health information will be sent to Counsyl for the purpose of carrier screening at their lab in the United States (address above). I also understand that LifeLabs will contact me for a new blood sample if a test result cannot be provided from the original blood sample. I acknowledge that LifeLabs will receive the results from Counsyl and it will disclose the results to the ordering physician. I also understand that I will be contacted by LifeLabs to obtain consent should LifeLabs be asked to disclose my information for another reason, other than as required or permitted by law. I acknowledge that I am responsible for the full cost of testing.	
Patient Sign Here: _____	Date: M M D D Y Y Y Y