Panorama Funded by MOHLTC

Must include **MOHLTC CHECKLIST**, page 2 of this document

Microdeletions are NOT funded - private pay

LifeLabs GENETICS™

1-844-363-4357 · Ask.Genetics@LifeLabs.com |
Appointment booking ON 1-877-849-3637 | BC 1-855-412-4495

panorama® natera prenatal screen

CONTRACT #:	LL: D660-01	**LifeLabs** Demographic Label
Physician Billing #:		
Ordering Physician:	Name	
Ordering Physician Address & Contact Info:	Tel: Fax:	**Panorama** Barcode Label
Physician Signature:	**Statement of Informed Consent:** I confirm that this patient has been informed about the details associated with the genetic test(s) ordered below including its risks, benefits and limitations, and has given consent to testing as may be required by applicable law.	
		Physician's Office Demographic Label
Copy to: ❑ Genetic Counsellor ❑Other Healthcare Provider	Name Tel: Fax:	
Bill to:	**Patient Pay *(patient ONLY pays for microdeletions if ordered)***	

Patient Name: (Last, First)		**Date of Birth:** (MMDDYYYY)
Patient Address:	**Health Card #:**	**Telephone #:**

Clinical Questions:

Twin/Multiple gestation/Vanishing Twin? ❑Y ❑N **Egg donor?** ❑Y ❑N **Surrogate?** ❑Y ❑N

*Panorama is **not** recommended for twins, multiple gestations, vanishing twins, egg donor or surrogate*

Due date(MMDDYYYY): _____ **Maternal Weight:** _____lbs

*Patient **must** be at least 9 weeks gestation at the time of blood collection*

TESTS REQUESTED

Singleton pregnancies ONLY, please select only one of the following options:

	LL TR
☐ **Panorama® Prenatal Test (no cost to patient)** Testing of chromosomes 21, 13, 18, X, Y and triploidy	**4010**
☐ **Panorama® Prenatal Test ($0) + 22q11.2 deletion ($195)** Testing of chromosomes 21, 13, 18, X, Y, triploidy, and 22q11.2 deletion	**4010 & 3037**
☐ **Panorama® Prenatal Test ($0) + Microdeletion Extended Panel [5] ($245)** Testing of chromosomes 21, 13, 18, X, Y, triploidy, 22q11.2 deletion, Cri-du-chat, 1p36 deletion, Angelman, Prader-Willi	**4010 & 3071**
☐ ***YES, include the baby's gender on the report (no cost)*** – if box is not ticked, gender will not be reported	

Date Blood Collected: (MMDDYYYY) _____ **Time Blood Collected:** (HH:MM) _____ **Collector Name:** _____

**** LIFELABS/CML STAFF: PHOTOCOPY REQUISITION & CHECKLIST, INCLUDE 1 COPY WITH SAMPLES IN BOX ****

Panorama Prenatal Test (13, 18, 21, X & Y) performed by LifeLabs Genetics (175 Galaxy Blvd., Suite 105, Toronto ON, M9W 0C9, Canada)

PATIENT CONSENT - MANDATORY:

I have read and signed the Patient Consent Form, which remains with the ordering physician. I understand that 2 blood samples [and a cheek swab from the father, if present and willing] will be taken by LifeLabs staff. I acknowledge that my sample(s) and personal health information will be sent to LifeLabs and/or Natera for the purpose of non-invasive prenatal testing at their addresses listed 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 samples. I acknowledge that LifeLabs will send the results to my ordering. In the event of a high risk or no result, I acknowledge that LifeLabs may contact my healthcare provider to obtain follow-up diagnostic information to ensure quality and accuracy in reporting.

Patient Sign Here: _____ **Date:** _____

Father Sign Here: _____ **Date:** _____

(ONLY if cheek swab sample provided)

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CHECKLIST

must be submitted with requisition

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Patient Name: (Last, First)	**Patient Healthcard #:**

The Provincial Council for Maternal and Child Health (PCMCH) has recommended specific indications for NIPT funding.
Please complete either Category I or II and attach to page 1 of the Panorama Funded by MOHLTC requisition.
Please confirm that your patient meets the following indications by checking the appropriate boxes:

CATEGORY I: For investigation of trisomy 21, 18 or 13 ONLY.

☐ **Singleton gestation** (Panorama NIPT is not recommended for twin pregnancies. NIPT in the context of twin pregnancies requires consultation with a geneticist or maternal fetal medicine specialist (see Section B)) with appropriate pre-test counselling including a discussion of the limitations of the test.

And any one of the following:

☐ A maternal multiple marker screening test (eg. FTS/IPS/Quad etc.) positive for aneuploidy.
☐ Women of advanced maternal age, defined as ≥ 40 years of age at expected time of delivery.
☐ Fetal nuchal translucency (NT) ≥ 3.5mm
☐ Pregnancy history of aneuploidy / previous child with aneuploidy.

Physician signature	**Date**

CSN# (Billing #)

CATEGORY II: There are several situations where additional specialist consultation is necessary to determine whether NIPT is warranted and to provide appropriate pre and post- test counselling. **NIPT funding for the following criteria must be submitted by a genetics or maternal fetal medicine (MFM) specialist.**

Risk indicators:

A/

☐ Fetal congenital anomalies identified on ultrasound, which are suggestive of trisomy 21, 18 or 13.
Specify: _____

OR:

B/

☐ Risk of aneuploidy for trisomy 21, 18 or 13 > than that of a positive maternal multiple marker screen.
- Women less than 40 years of age at expected date of delivery must have at least one other risk factor noted.
- The risk of aneuploidy can be calculated by including any combination of risk indicators including soft markers, biochemistry, maternal age, etc.

Please indicate all risk factors present

☐ Twin pregnancy (Panorama NIPT is not recommended for twin pregnancies)
☐ Soft markers (check all that apply):

	Absent nasal bone		Increased nuchal fold / edema
	Choroid plexus cysts		Increased nuchal translucency
	Clinodactyly		Intracardiac echogenic focus / foci
	Cystic hygroma		Short femur
	Hyperechogenic bowel		Short humerus
	Hypoplastic nasal bone		Ventriculomegaly

☐ Maternal age: _____

☐ Other, specify: _____

OR:

C/

☐ NIPT for sex chromosome determination (at least one of the following):
- ☐ risk of a sex-limited disorder
- ☐ ultrasound findings suggestive of either a sex chromosome aneuploidy
- ☐ ultrasound findings suggestive of a disorder of sex determination (DSD)

Genetics or MFM specialist's name (Please print)

Physician Signature	**Date**

CSN# (Billing #)	**Genetics or MFM Centre**