

1-844-363-4357 Ask.Genetics@LifeLabs.com

Appointment booking can be done at www.lifelabs.com

Ordering Physician Billing #:				LifeLabs Demographic Label
Ordering Physician:	Name			
Ordering Physician Address & Contact Information:	Tel:	Fax:		
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.			Demographic Label
Copy to: <input type="checkbox"/> Genetic Counsellor <input type="checkbox"/> Other Healthcare Provider	Name Tel: _____ Fax: _____			
Bill to:	Bill Type: OHIP 'H' (patient ONLY pays for Microdeletions if ordered)			

Patient Last Name:	Patient First Name:	Date of Birth:								
		<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	M	M	D	D	Y	Y	Y	Y
M	M	D	D	Y	Y	Y	Y			
Unit #:	Street:	City:	Province:	Postal Code:						

Ontario Health Card #:	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>#</td><td>#</td><td>#</td><td>#</td><td>#</td><td>#</td><td>#</td><td>#</td><td>#</td><td>#</td><td>V</td><td>C</td> </tr> </table>	#	#	#	#	#	#	#	#	#	#	V	C	Patient Telephone #: () -
#	#	#	#	#	#	#	#	#	#	V	C			

CLINICAL QUESTIONS	Twin/Multiple gestation/Vanishing Twin? <input type="checkbox"/> Y <input type="checkbox"/> N Egg donor? <input type="checkbox"/> Y <input type="checkbox"/> N Surrogate? <input type="checkbox"/> Y <input type="checkbox"/> N <i>Panorama is not recommended for twins, multiple gestations, vanishing twins, egg donor or surrogate</i>										
	Due Date: <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> <i>Patient must be at least 9 weeks gestation at the time of blood collection</i>			M	M	D	D	Y	Y	Y	Y
	M	M	D	D	Y	Y	Y	Y			
Maternal Weight: _____ lbs.											

TESTS REQUESTED

Singleton pregnancies ONLY please select only one of the following options: <input type="checkbox"/> Panorama® Prenatal Test (no cost to patient) <small>Testing of chromosomes 21, 13, 18, X, Y and triploidy</small> <input type="checkbox"/> Panorama® Prenatal Test + 22q11.2 deletion (\$195) <small>Testing of chromosomes 21, 13, 18, X, Y, triploidy, and 22q11.2 deletion</small> <input type="checkbox"/> Panorama® Prenatal Test + Microdeletion Extended Panel [5] (\$245) <small>Testing of chromosomes 21,13,18,X,Y, triploidy, 22q deletion, Cri-du-chat,1p36 deletion, Angelman, Prader-Willi</small> <input type="checkbox"/> YES, include the sex of the baby on the report (no cost) – if the box is not ticked, the sex of the baby will not be reported	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>LL TR</td> </tr> <tr> <td>5518</td> </tr> <tr> <td>5518 & 3037</td> </tr> <tr> <td>5518 & 3071</td> </tr> </table>	LL TR	5518	5518 & 3037	5518 & 3071
LL TR					
5518					
5518 & 3037					
5518 & 3071					

Date Blood Collected:	Time Blood Collected:	Collector Name:												
<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	M	M	D	D	Y	Y	Y	Y	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>H</td><td>H</td><td>M</td><td>M</td> </tr> </table>	H	H	M	M	
M	M	D	D	Y	Y	Y	Y							
H	H	M	M											

** LIFELABS/BCBio STAFF: PHOTOCOPY REQUISITION, INCLUDE 1 COPY WITH SAMPLES **
 Panorama Prenatal Test 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 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 LifeLabs Genetics. 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 physician and, if testing is performed at Natera, LifeLabs will receive results from Natera and send the results to my ordering physician. Should we be asked to disclose information about you for another reason, other than as required or permitted by law, we will contact you to obtain your consent. 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:

M	M	D	D	Y	Y	Y	Y
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Patient Name: (Last, First)	Patient Healthcard #:
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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.
Ordering physician on page 1 must match physician information/signature on page 2 CHECKLIST

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) ≥ 3.5 mm
 Pregnancy history of aneuploidy / previous child with aneuploidy.

Physician signature	Date
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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.
- o Women less than 40 years of age at expected date of delivery must have at least one other risk factor noted.
 - o 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)	
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Physician Signature	Date
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CSN# (Billing #)	Genetics or MFM Centre
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