Private Pay

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

Appointment booking can be done at www.lifelabs.com

Ordering Physician Billing #:	Physician OHIP# (Ontario) Physician MSC# (British Columbia) Other Provinces: 999
Ordering Physician:	Name
Ordering Physician Address & Contact Information:	Tel: Fax:
Physician Signature	
Copy-to Client:	Name Tel: Fax:
Bill to:	**Bill type "P"** (patient to pay at time of service)

LifeLabs
Demographic Label

Counsyl Barcode Label

Patient Last Name:	**Patient First Name:**	**Sex:** ☐M ☐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? ❑ Yes ❑ No

Reason for testing (select all that apply):
- ❑ Family history
- ❑ Screening for genetic carrier status
- ❑ Consanguinity
- ❑ Supervision, normal 1st pregnancy
- ❑ Supervision, other normal pregnancy
- ❑ High risk ethnicity
- ❑ Other: _____

Ethnicity (select all that apply):
- ❑ Northern European *e.g. British, German*
- ❑ Southern European *e.g. Italian, Greek*
- ❑ French Canadian or Acadian
- ❑ Ashkenazi Jewish
- ❑ Other/Mixed Caucasian
- ❑ East Asian *e.g. Chinese, Japanese*
- ❑ South Asian *e.g. Indian, Pakistani*
- ❑ Southeast Asian *e.g. Filipino, Vietnamese*
- ❑ African or African American
- ❑ Hispanic
- ❑ Middle Eastern
- ❑ Indigenous
- ❑ Pacific Islander
- ❑ Unknown

TESTS REQUESTED

Expanded Carrier Screen (Counsyl Foresight™) Carrier screening panel that performs sequencing of over 175 clinically significant conditions	**LL TC** **4101**	**Mnemonic** **FP2**

Sample Type: ❑ Blood (EDTA: 4mL) ❑ Saliva (Oragene OG-510: Available by request)

Date Sample Collected: M M D D Y Y Y Y	**Time Sample Collected:** H H M M	**Collector Name:**

PARTNER INFORMATION

** if your partner has already performed the Counsyl Expanded Carrier Screen*

Partner Name:	**Partner DOB:** M M D D Y Y Y Y **Date Partner tested:** M M D D Y Y Y Y	**Partner Barcode #:** From original report

**** 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

Expanded Carrier Screen (Counsyl Foresight™) – Payment Authorization

(To be completed and signed by the patient)

Please send this credit card payment form with the laboratory requisition and sample to:

B.C. Patients
LifeLabs
Attn: Specimen Management
3680 Gilmore Way
Burnaby, BC
V5G 4V8

All other provinces & territories
LifeLabs
Attn: Specimen Management
37 Voyager Court
Toronto,ON
M9W 4Y2

PLEASE PRINT (Patient 1):

Last Name	First Name	Initial
Birth Date (dd/mm/yyyy)	Phone Number	
E-mail		
Address		
City	Province	Postal Code

☐ **Expanded Carrier Screen (Counsyl Foresight™)** **$ 629.00**
Carrier screening panel that detects specific mutations across more than175 clinically significant genes

PAYMENT

❑ Visa ❑ Mastercard

CREDIT CARD NUMBER

EXP. DATE (MM/YY)

TOTAL AMOUNT

$ 629.00 CAD

I understand that my credit card will be charged for the full amount of testing.

CREDIT CARD HOLDER _____ SIGNATURE _____ DATE _____