California Department of PublicHealth

cfDNA Consent & Order Form

Recommended G.A. Range: 10 Weeks 0 Days - 21 Weeks 0 Days

For lab use only
Do not cover

Blue/black ink | * = required | MM/DD/YYYY date format | Fill boxes completely | A Capital Letters

1. Patient Information

Last Name* | First Name* | Int. | Maiden Name

Biological Date of Birth* (M M / D D / Y Y Y Y) | Social Security # (- -) | Medical Record # | Most Recent Weight (.) ☐ lbs ☐ kg

Race and Ethnicity (Select up to 4 that apply or "Unknown")

- ☐ Black
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian
- ☐ Hawaiian
- ☐ Japanese
- ☐ Korean
- ☐ Lao
- ☐ Latinx/Hispanic
- ☐ Middle Eastern
- ☐ Native American
- ☐ Samoan
- ☐ South Asian
- ☐ Other Southeast Asian
- ☐ Vietnamese
- ☐ White
- ☐ Other
- ☐ Unknown

Most Recent Height: ☐☐ ft ☐☐ in OR ☐☐☐ cm

Patient Street Address* (for medical/confidential mail) | Address Line 2 (APT, STE, UNIT, etc.)

City* | State* | ZIP Code* | Patient Phone #* (- -)

2. Pregnancy Information

Number of Fetuses* ☐ 1 ☐ 2 ☐ Unknown | Disclose Fetal Sex* ☐ Yes ☐ No

Estimated Due Date* (M M / D D / Y Y Y Y)

Get the Estimated Due Date by using a Dating Method and Gestational Age Calculator at: https://calgenetic.cdph.ca.gov/resources/

Was IVF/Ovum Donor used for this pregnancy?* ☐ Yes ☐ No

Ovum Donor Age at Egg Retrieval ☐☐ Years

3. Clinician & Facility Information (Clinician must be a licensed medical professional)

Last Name* | First Name*

Medical License Type*

- ☐ MD
- ☐ DO
- ☐ PA
- ☐ NP
- ☐ CNM
- ☐ Other

Medical License #* | NPI #*

Facility Name* | Facility Phone #* (- -) | Ext.

Facility Street Address* | Address Line 2 (BLDG, FL, STE, etc.)

City* | State* | ZIP Code* | Facility Fax # (- -)

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Form Completed By*

Patient Last Name*

Patient Date of Birth* M M / D D / Y Y Y Y

4. Billing Information

Bill To* (Choose one, to allow correct billing, provide Medi-Cal or other insurance information.)

☐ Insurance ☐ Medi-Cal ☐ Self Pay

Policy or Medi-Cal #

Group ID

Insurance Provider Name

Relationship to Insured (If patient is not the primary insured, provide insured details which are required for billing.)

☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Last Name

Insured First Name

Insured Date of Birth M M / D D / Y Y Y Y

Insured Sex ☐ Female ☐ Male

Insured Phone # - -

5. Select One cfDNA Processing Lab

Specimen may be sent to an alternative lab, at GDSP discretion.

☐ Natera (Vasistera SNP Based NIPT)

☐ Revvity Omics Vanadis cfDNA (Sun Clinical/Allied Labs)

☐ Quest Dx (GDSP cfDNA Panel) CL: 94804005

6. Patient Consent

If you give consent to prenatal screening by signing below, your blood will be collected and sent to a state-contracted laboratory for prenatal screening.

- *I consent to participate in the California Prenatal Screening Program.*
- *I authorize the release of medical and any other information about myself needed for my health insurance claim.*
- *I authorize payment of medical benefits to the Genetic Disease Screening Program (GDSP) for services provided to me.*
- *I consent to be billed directly for the services provided to me if I do not have health insurance coverage or Medi-Cal.*
- *I informed my provider whether to disclose fetal sex through the California Prenatal Screening Program.*

Date* M M / D D / Y Y Y Y

X

Signature of Patient/Authorized Person*

☐ *Attestation that verbal consent from patient was obtained:*

Provider/Representative Name

Relationship to Patient

7. Blood Sample

Blood Draw Facility Name*

Blood Draw Date* M M / D D / Y Y Y Y

Collector's Initials*

Blood Draw Facility Phone #* - -