

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* Biological Date of Birth* Social Security # MM MM MM MM MM MM MM MM MM	Int. Maiden Name dical Record # Most Recent Weight lbs ¬kg	
Race and Ethnicity (Select up to 4 that apply or "Unknown") Black Hawaiian Middle Eastern Cambodian Japanese Native American Chinese Korean Samoan Filipino Lao South Asian Guamanian Latinx/Hispanic	Most Recent Height Vietnamese White Other Unknown	
Patient Street Address* (for medical/confidential mail) City* 2. Pregnancy Information	Address Line 2 (APT, STE, UNIT, etc.) State* ZIP Code* Patient Phone #*	
Number of Fetuses*		
Was IVF/Ovum Donor used for this pregnancy?* Pyes No Ovum Donor Age at Egg Retrieval Years 3. Clinician & Facility Information (Clinician must be a licensed medical professional)		
Last Name* Medical License Type* MD DO PA NP CNM Dother	First Name* Medical License #* NPI #*	
Facility Name* Facility Street Address*	Facility Phone #* Ext. 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	g, provide Medi-Cal or other insurance	information.)	
□ Insurance □ Medi-Cal □ Self Pay			
Policy or Medi-Cal # Group ID	Insurance Provider Na	me	
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	e	
Insured Date of Birth Insured Se			
MM/DD/YYYY - Female	e □ Male	-	
E Soloct One of DNA Processing	Tlah Chasiman may be contto an	Itarnativa lab at CDCD dispration	
5. Select One cfDNA Processing	<u> </u>		
□ Natera (Vasistera SNP Based NIPT) □	9	□ Quest Dx (GDSP cfDNA Panel) CL: 94804005	
6. Patient Consent	(Sun Clinical/Allied Labs)	CL. 94604003	
If you give consent to prenatal screening b		ollected and sent to a state-	
contracted laboratory for prenatal screeni			
• I consent to participate in the California P			
• 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*	
X			
Signature of Patient/Authorized Person*			
☐ Attestation that verbal consent from pat	tient was obtained:		
Provider/Representative Name	Relationship to	Patient	
7. Blood Sample			
•			
Blood Draw Facility Name*			
Blood Draw Date* Collector's Initi	als* Blood Draw Facility Phone #*		
MM/DD/YYYY			