12117 Bee Caves Rd. Building III, Suite 100 Austin, TX 78738
Tel: (844) 277-4721 Fax: (866) 283-3634 e-mail: support@ASPiRALAB.com
CLIA: 45D2073394 CAP: 9021192 NYS: 8885
Laboratory Director: Dr. Herbert Fritsche PhD

ASPIRA LABS®

Laboratory Test Requisition Form

TO AVOID DELAYS PLEASE COMPLETE FIELDS IN RED

Collection Date: _____ **Phlebotomist Initials:** _____ ☐ Physician Office ☐ Draw Site ☐ Other

Sample Type: ☐ Blood (1, 4 mL EDTA Lavender top tube) ☐ Saliva ☐ Other:_____

ASPIRA GENETIX Carrier Screening (select panel)

○ **Core Panel (6 genes)** (GTS- 200)
○ **Targeted Panel** (GTS-205)
○ **Ashkenazi Jewish Targeted** (GTS-210)
○ **Expanded Carrier Screening** (GTS-225)

Male partner testing will not include X-linked genes. For the latest test offerings and list of genes please refer to https://aspirawh.com

PROVIDER INFORMATION

Physician name(s): _____ NPI#: _____

Name/Account #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address:_____

Fax copy to: _____

PATIENT INFORMATION

Last name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address:_____

SSN: _____ DOB (mm/dd/yy): __ __ / __ __ / __ __ __ __

Phone number: _____

Ethnicities (Check all that apply) Gender: M / F

☐ Caucasian ☐ Ashkenazi Jewish ☐ Sephardic Jewish
☐ East Asian ☐ South East Asian ☐ Hispanic
☐ Native American ☐ African American ☐ Other:_____

PHYSICIAN SIGNATURE

I attest that the patient has signed an informed consent or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. My signature certifies that I am a licensed medical professional or his/her representative who is authorized to order genetic tests on his/her behalf. The patient has been given the opportunity to ask questions about the attached consent and to seek outside genetic counseling.

STATEMENT OF MEDICAL NECESSITY
By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

Physician Signature: _____

Print Name: _____ Date: _____

PATIENT AUTHORIZATION

I have read the Informed Consent document and I give permission to ASPIRA LABS® to perform genetic testing as described. I affirm that my physician has offered genetic counseling and has reviewed and explained the benefits, risks, and limitations of the genetic test(s) to my satisfaction; that I have read and signed the informed consent form; and I would like to proceed with the genetic test(s). I also give permission for my specimen and clinical information to be used in de-identified studies as ASPiRA LABS and for publication of study results, if appropriate ("Research"), or I have checked the box below to opt out of Research. My name or other personal identifying information will not be used in or linked to the results of any studies and publications. More information is available at https://aspirawh.com/about-us/legal/

☐ Opt out of Research

Patient's Signature: _____

Print Name: _____ Date: _____

BILLING INFORMATION

☐ Private Insurance ☐ Medicare ☐ Patient Self-Pay ☐ Medicaid ☐ Ordering Facility (Client Bill)

Insurance Information: Attach a copy of front and back of patient insurance card and complete.

Primary insurance carrier: _____ Member ID#: _____ Group ID#: _____

Secondary insurance carrier: _____ Member ID#: _____ Group ID#: _____

Name of insured: Last: _____ First: _____ DOB: _ _/ _ _/ _ _ _ _

Relationship to insured:
☐ Self ☐ Spouse ☐ Dependent ☐ Other

ICD-10 Codes: _____ /_____ /_____ /_____ /_____ /_____

Please see page 2 for a list of commonly used codes

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Laboratory Test Requisition Form

ASPIRA LABS®

Please attach detailed medical records, insurance card front/back, and clinical information to the requisition form.

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CLINICAL HISTORY

Attach any available detailed medical records and clinical notes

Clinical Details

Check all that apply:

- ☐ Known trans-location carrier - Karyotype:
- ☐ Bone Marrow Transplant

Please specify any that are checked above:

There are many factors which may affect genetic diagnostic testing: such as gene-gene interactions, high-risk ethnicity groups, and transplants. Please list any that may apply.

Has the patient had any previous genetic testing? If yes, please list genes and results, if known.

FAMILY HISTORY

Attach pedigree and additional pages as needed

FAMILY MEMBER 1 NAME	RELATION TO PATIENT	GENETIC SEX ◯ Male ◯ Female ◯ Unknown	
DIAGNOSIS AND/OR SYMPTOMS		AGE OF ONSET	DOB (MM/DD/YYYY)
FAMILY MEMBER 2 NAME	RELATION TO PATIENT	GENETIC SEX ◯ Male ◯ Female ◯ Unknown	
DIAGNOSIS AND/OR SYMPTOMS		AGE OF ONSET	DOB (MM/DD/YYYY)
FAMILY MEMBER 3 NAME	RELATION TO PATIENT	GENETIC SEX ◯ Male ◯ Female ◯ Unknown	
DIAGNOSIS AND/OR SYMPTOMS		AGE OF ONSET	DOB (MM/DD/YYYY)

INSTRUCTIONS

1. Complete the patient and provider information section.
2. Have the patient read and sign the Informed Consent form. The complete patient informed consent form for genetic testing can be found on aspirawh.com. Signature from the provider on Page 1 of the TRF is required for all testing. Signature from the primary patient is only required for billing purposes.
3. Select the test and indicate any relevant test options. Please call us if you have any questions.
4. Merged couple reports will only be produced if the the partner's sample, information, and consent to testing is submitted with the primary patient's sample and TRF.
5. Please visit aspirawh.com for specimen requirements.

REQUIRED FOR INSURANCE CHECKLIST

- ☐ Detailed medical record (pedigree if available)
- ☐ ICD-10 code(s)
- ☐ Physician and patient signatures
- ☐ Copy of insurance card(s) - front / back
- ☐ Insurer specific forms (e.g. ABN)
- ☐ Insurance authorization, if available
- ☐ For Medicare, Patient history information is required

COMMONLY USED ICD-10 CODES

- ☐ Z13.71 Encounter for nonprocreative screening for genetic disease carrier status
- ☐ Z13.79 Encounter for other screening for genetic and chromosomal anomalies
- ☐ Z14.1 Cystic fibrosis carrier
- ☐ Z14.8 Genetic Carrier of other disease
- ☐ Z15.81 Genetic susceptibility to multiple endocrine neoplasia [MEN]
- ☐ Z31.430 Encounter of female for testing for genetic disease carrier status for procreative management
- ☐ Z31.440 Encounter of male for testing for genetic disease carrier status for procreative management
- ☐ Z31.5 Encounter for procreative genetic counseling
- ☐ Z36.0 Encounter for antenatal screening for chromosomal anomalies
- ☐ Z36.81 Encounter for antenatal screening for hydrops fetalis
- ☐ Z36.89 Encounter for other specified antenatal screening
- ☐ Z36.9 Encounter for antenatal screening, unspecified
- ☐ Z81.0 Family history of intellectual disabilities
- ☐ Z36.8A Encounter for antenatal screening for other genetic defect
- ☐ Z84.81 Family history of carrier of genetic disease
- ☐ Z82.79 Family history of other congenital malformations, deformations and chromosomal abnormalities