Shodair Children's Hospital Genetics Laboratory
2755 Colonial Dr, Helena. MT, 59601
Phone (406) 444-7532 Toll Free (800) 447-6614
Fax (406) 444-1022
email: mtgene@shodair.org

NONINVASIVE PRENATAL SCREENING (NIPS)

PATIENT INFORMATION

Counsyl will use this information to contact the patient via e-mail, SMS, and/or phone regarding screen processing status and online result access. By submitting this requisition, I confirm that I have obtained the patient's authorization to be contacted by Counsyl.

_____
Last Name

_____ _____
First Name **MI**

_____ / _____ / _____ Sex:
Date of Birth ☐ Female ☐ Male

_____ _____
Patient e-mail address *(required)* Patient Phone # *(required)*

_____
Patient Address

_____ _____ _____
City State ZIP

Ethnicity *select all that apply*

- ❑ Northern European *e.g. British, German*
- ❑ Southern European *e.g. Italian, Greek*
- ❑ French Canadian or Cajun
- ❑ East Asian *e.g. Chinese, Japanese*
- ❑ South Asian *e.g. Indian, Pakistani*
- ❑ Southeast Asian *e.g. Filipino, Vietnamese*
- ❑ African or African American
- ❑ Other/Mixed Caucasian
- ❑ Ashkenazi Jewish
- ❑ Hutterite
- ❑ Hispanic
- ❑ Middle Eastern
- ❑ Native American
- ❑ Pacific Islander
- ❑ Unknown

ORDERING HEALTH CARE PROFESSIONAL

Name: _____

NPI#: _____

Address: _____

City, State, Zip: _____

Telephone:(_____)_____ FAX:(_____)_____

REFERRING Facility:_____

AUTHORIZATION

By submitting this requisition , I confirm that I have obtained the patient's informed consent for the requested screening. I confirm that this screen is clinically valuable for the patient.

_____ _____
Signature of healthcare provider **Date**

CLINICAL INDICATIONS

Required. Codes below are not exhaustive

***Provide details and attach report with sample**

- ❑ Advanced maternal age, 1st pregnancy O09.519, O09.511, O09.512, O09.513
- ❑ Advanced maternal age, not 1st pregnancy O09.529, O09.521, O09.522, 09.523
- ❑ Abnormal U/S, non-CNS* O28.3
- ❑ Abnormal U/S, CNS* O35.0XX0
- ❑ Abnormal maternal serum screen* O28.9
- ❑ Chromosome abnormality suspected in fetus* O35.0XX0
- ❑ Previous pregnancy/child affected with chromosome abnormality O35.2XX0
- ❑ Family History* Z84.89
- ❑ Supervision, other high-risk pregnancy O09.891, O09.892, O09.893
- ❑ Supervision, normal 1st pregnancy Z34.00, Z34.01, Z34.02, Z34.03
- ❑ Supervision, other normal pregnancy Z34.80, Z34.81, Z34.82, Z34.83
- ❑ Other ICD-10 codes: _____

REQUIRED INFORMATION

_____
Estimated Due Date

_____ft _____in
Maternal height

_____lbs
Maternal weight

_____
NT ultrasound date

_____mm _____mm
NT Twin B

_____cm _____cm
CL Twin B

Dating Method:
☐ U/S ☐ LMP ☐ PE ☐ IVF

Pregnancy type:
☐ Singleton (or unknown) ☐ Twins

Was pregnancy conceived by IVF/ART?
☐ Yes ☐ No

If yes, ovum donor used?
☐ Yes ☐ No

If yes, age of donor at time of donation?

NONINVASIVE PRENATAL SCREENING (NIPS)

Specimen Requirements: Use 10mL blood collection kit *(2 tubes blood must be drawn after 10 weeks)*
Sample Collection Date: _____

Select at least one

- ❑ Common aneuploidy, chromosome 13, 18, 21
- ❑ Include sex chromosome analysis*
- ❑ Include microdeletions, *singleton only*

**Twin sex chromosome analysis only for presence of Y chromosome DNA*

If fetal demise has occurred or there are higher order multiples, NIPT screen cannot be performed

INTERNAL USE ONLY

Med Rec #	Admit #	Date Received	Patient Barcode

Shodair Children's Hospital Genetics Laboratory
2755 Colonial Dr, Helena. MT, 59601
Phone (406) 444-7532 Toll Free (800) 447-6614
Fax (406) 444-1022
email: mtgene@shodair.org

NONINVASIVE PRENATAL SCREENING (NIPS)

Patient Name: _____ **DOB:** _____

INSTITUTIONAL BILLING

Institution: _____ Billing Contact: _____

Address: _____ Phone #: _____

City, State, Zip: _____ Fax #: _____

MEDICAID

Name of policy holder: _____ Passport #: _____

Policy holder DOB: _____ Phone #: _____

Address: _____ **MEDICAID** #: _____

City, State, Zip: _____ Medicaid State: _____

SELF PAY

Name of responsible party: _____

Relationship to patient: _____

Phone #: _____

INSURANCE BILLING

Name of policy holder: _____ Phone #: _____

Policy holder DOB: _____ Ins. Co. / Policy #: _____

Patient Relation to Policy Holder: _____ Ins. Co Contact / Phone: _____

SS # (Guarantor): _____

Address: _____

City, State, Zip: _____

Prior-Authorization Assistance *

❑ **YES** ❑ **NO** ❑ **N/A**

If Yes, please provide all clinical information

* PRIOR-AUTHORIZATION ASSISTANCE

Shodair's goal is to make the process of finding answers through genetic screening as easy as possible for patients and providers by providing assistance with the insurance benefit investigation / preauthorization process for noninvasive prenatal screening. Shodair will perform a benefits investigation with the insurance plan listed above. For covered services, we will complete a prior-authorization when indicated. If the patient opts to not pursue testing, the ordering provider will be contacted. For non-covered services, we will contact the patient and offer a self-pay option. In the event we do not hear back from the patient in a 24 hour period, we will default to billing the insurance.

Preferred method(s) for contacting patient: _____

Pay your bill securely online at shodair.org/paying for services

INTERNAL USE ONLY

Med Rec #	Admit #	Date Received	Patient Barcode