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	**LifeLabs** Demographic Label
Ordering Physician:	Name	
Ordering Physician Address & Contact Information:	Tel: Fax:	
Physician Signature		
Copy-to Client:	Name Tel: Fax:	Counsyl Barcode Label
Bill to:	**Bill type "P"** (patient to pay at time of service)	

Patient Last Name:	**Patient First Name:**	**Sex:**	**Date of Birth:**
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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™)	**LL TC**	**Mnemonic**
Carrier screening panel that performs sequencing of over 175 clinically significant conditions	**4101**	**FP2**
❑ **FIRST TIME USER** – please check this option if neither partner has been tested	**3901**	**FPP**
❑ **PARTNER** – please check this option if a previous sample has been submitted for your patient's partner		

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

Date Sample Collected:	**Time Sample Collected:**	**Collector Name:**
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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	**Partner Barcode #:** From original report
	Date Partner tested:	M M D D Y Y Y Y	

**** 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