

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		Counsyl Barcode Label
Copy-to Client:	Name Tel: _____ Fax: _____	
Bill to:	Bill type "P" (patient to pay at time of service)	

Patient Last Name:	Patient First Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: M M D D Y Y Y Y		
Unit #:	Street:	City:	Prov.:	Postal Code:	Patient Telephone #: () -

PATIENT INFORMATION (REQUIRED)	Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for testing (select all that apply):	Ethnicity (select all that apply):
<input type="checkbox"/> Family history <input type="checkbox"/> Screening for genetic carrier status <input type="checkbox"/> Consanguinity <input type="checkbox"/> Supervision, normal 1st pregnancy <input type="checkbox"/> Supervision, other normal pregnancy <input type="checkbox"/> High risk ethnicity <input type="checkbox"/> Other: _____	<input type="checkbox"/> Northern European e.g. <i>British, German</i> <input type="checkbox"/> Southern European e.g. <i>Italian, Greek</i> <input type="checkbox"/> French Canadian or Acadian <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Other/Mixed Caucasian <input type="checkbox"/> East Asian e.g. <i>Chinese, Japanese</i> <input type="checkbox"/> South Asian e.g. <i>Indian, Pakistani</i> <input type="checkbox"/> Southeast Asian e.g. <i>Filipino, Vietnamese</i> <input type="checkbox"/> African or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Indigenous <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Unknown

TESTS REQUESTED		
<input type="checkbox"/> Expanded Carrier Screen (Counsyl Foresight™) - \$495 <small>Carrier screening panel that performs sequencing of over 175 clinically significant conditions</small>	<u>LL TC</u> 3900	<u>Mnemonic</u> DEB

Sample Type: <input type="checkbox"/> Blood (EDTA: 4mL) <input type="checkbox"/> Saliva (Oragene OG-510: Available by request)
Date Sample Collected: M M D D Y Y Y Y
Time Sample Collected: H H M M
Collector Name: _____

PARTNER INFORMATION			
<small>* if your partner has already performed the Counsyl Expanded Carrier Screen</small>			
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:	
<p>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.</p>	
Patient Sign Here: _____	Date: M M D D Y Y Y Y