LifeLabs Genetics™

Private Pay

Counsyl

1-844-363-4357 · Ask.Genetics@LifeLabs.com

Report to Physician #:	Physician OHIP# (Ontario): Physician MSC# (British Columbia): Other Provinces: 999
Ordering Physician Name:	Name
Ordering Physician Address:	Address Tel: Fax:
Physician Signature:	
Copy to (Name):	Name Tel: Fax:
Bill to:	Patient to Pay - type "P" (Counsyl: Bill to Clinic)

LifeLabs Demographic Label

Additional LifeLabs Label (if needed)

Counsyl Barcode
(For Reference Labs use only- KRL/IRL/BRL/VRL)

Patient Name (Last, First):

Date of Birth: _____/_____/_____
MM DD YYYY

Provincial Health Number:

Sex: ❑ **M** ❑ **F**

Patient address:

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 Cajun
- ❑ 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
- ❑ Native American
- ❑ Pacific Islander
- ❑ Unknown

TESTS REQUESTED	**LL TR/CML/Mnemonic**
❑ **Counsyl Family Prep Screen 1.0 (Targeted mutations)** Carrier screening panel that detects specific mutations across 102 clinically significant genes	**4100/4100/FP1**
❑ **Counsyl Family Prep Screen 2.0 (Full sequencing)** Carrier screening panel that performs sequencing of102 clinically significant genes	**4101/4101/FP2**

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

_____ _____/_____/_____
Name of partner (if also tested) Partner's DOB: MM/DD/YYYY

_____/_____/_____ _____:_____ _____
Date Blood Collected (MM/DD/YYYY) **Time Blood Collected (HH:MM)** **Collector's Name**

**** PHOTOCOPY REQUISITION AND INCLUDE ORIGINAL WITH SAMPLE ****

(Testing performed at Counsyl Inc., 180 Kimball Way South, San Francisco CA, 94080)

PATIENT CONSENT

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 will send the result to my ordering physician. I acknowledge that I am responsible for the full cost of testing. ,

Patient Sign Here: _____ **Date:** _____