California Department of PublicHealth

cfDNA Consent & Order Form

Recommended G.A. Range: 10 Weeks 0 Days - 21 Weeks 0 Days

For lab use only
Do not cover

Blue/black ink | * = required | MM/DD/YYYY date format | Fill boxes completely | A Capital Letters

1. Patient Information

Last Name* | First Name* | Int. | Maiden Name

Biological Date of Birth* (M M / D D / Y Y Y Y) | Social Security # (- -) | Medical Record # | Most Recent Weight (.) ☐ lbs ☐ kg

Race and Ethnicity (Select up to 4 that apply or "Unknown")

- ☐ Asian/East Indian
- ☐ Black
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian
- ☐ Hawaiian
- ☐ Japanese
- ☐ Korean
- ☐ Lao
- ☐ Latinx/Hispanic
- ☐ Middle Eastern
- ☐ Native American
- ☐ Samoan
- ☐ Other Southeast Asian
- ☐ Vietnamese
- ☐ White
- ☐ Other
- ☐ Unknown

Most Recent Height

☐☐ ft ☐☐ in OR ☐☐☐ cm

Patient Street Address* (for medical/confidential mail) | Address Line 2 (APT, STE, UNIT, etc.)

City* | State* | ZIP Code* | Patient Phone #* (- -)

2. Pregnancy Information

Number of Fetuses* ☐ 1 ☐ 2 ☐ Unknown | Disclose Fetal Sex* ☐ Yes ☐ No

Estimated Due Date* (M M / D D / Y Y Y Y)

ⓘ Get the Estimated Due Date by using a Dating Method and Gestational Age Calculator at: https://calgenetic.cdph.ca.gov/resources/

Was IVF/Ovum Donor used for this pregnancy?* ☐ Yes ☐ No

Ovum Donor Age at Egg Retrieval ☐☐ Years

3. Clinician & Facility Information (Clinician must be a licensed medical professional)

Last Name* | First Name*

Medical License Type*

☐ MD ☐ DO ☐ PA ☐ NP ☐ CNM ☐ Other

Medical License #* | NPI #*

Facility Name* | Facility Phone #* (- -) | Ext.

Facility Street Address* | Address Line 2 (BLDG, FL, STE, etc.)

City* | State* | ZIP Code* | Facility Fax # (- -)