cfDNA Consent & Order Form

California Department of Public Health

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* MM/DD/YYYY | Social Security # - - | Medical Record # | Most Recent Weight . lbs kg

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

- Black
- Cambodian
- Chinese
- Filipino
- Guamanian
- Hawaiian
- Japanese
- Korean
- Lao
- Latinx/Hispanic
- Middle Eastern
- Native American
- Samoan
- South Asian
- 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

Ovum Donor used for this pregnancy?* ☐ Yes ☐ No

Disclose Fetal Sex* ☐ Yes ☐ No

Estimated Due Date* MM/DD/YYYY

Calculate the Estimated Due Date here: https://calgenetic.cdph.ca.gov/resources/

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 # - -

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Form Completed By*

Patient Last Name*

Patient Date of Birth* MM / DD / YYYY

4. Billing Information

Bill To* (Choose one, to allow correct billing, provide Medi-Cal or other insurance information.)

- ☐ Insurance ☐ Medi-Cal ☐ Self Pay

Policy or Medi-Cal #

Group ID

Insurance Provider Name

Relationship to Insured (If patient is not the primary insured, provide insured details which are required for billing.)

- ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Last Name

Insured First Name

Insured Date of Birth MM / DD / YYYY

Insured Sex ☐ Female ☐ Male

Insured Phone # - -

5. Select One cfDNA Processing Lab

Specimen may be sent to an alternative lab, at GDSP discretion.

- ☐ Natera (Vasistera SNP Based NIPT)
- ☐ Revvity Omics Vanadis cfDNA (Allied Laboratory)
- ☐ Quest Dx (GDSP cfDNA Panel) CL: 94804005

6. Patient Consent

If you give consent to prenatal screening by signing below, your blood will be collected and sent to a state-contracted laboratory for prenatal screening.

- *I consent to participate in the California Prenatal Screening Program.*
- *I authorize the release of medical and any other information about myself needed for my health insurance claim.*
- *I authorize payment of medical benefits to the Genetic Disease Screening Program (GDSP) for services provided to me.*
- *I consent to be billed directly for the services provided to me if I do not have health insurance coverage or Medi-Cal.*
- *I informed my provider whether to disclose fetal sex through the California Prenatal Screening Program.*

X

Signature of Patient/Authorized Person*

Date* MM / DD / YYYY

☐ *Attestation that consent from patient was obtained:*

Provider/Representative Name

Relationship to Patient

7. Blood Sample

Blood Draw Facility Name*

Blood Draw Date* MM / DD / YYYY

Collector's Initials*

Blood Draw Facility Phone #* - -