Beacon Carrier Screening

Please attach detailed medical records, insurance card front/back, and clinical information to the requisition form.

Tesis Labs / 1408 Horizon Ave, Ste 101, Lafayette CO 80026 / Ph: 720-726-2130 / info@tesislabs.com

PRIMARY PATIENT

LAST NAME	FIRST NAME
DATE OF BIRTH (MM/DD/YYYY)	GENETIC SEX ◯ Male ◯ Female ◯ Unknown
MED REC#/PATIENT IDENTIFIER	ETHNICITY

ADDRESS

CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY

PHONE	EMAIL
SAMPLE DRAW DATE (MM/DD/YYYY)	SAMPLE TYPE ◯ Blood ◯ Buccal ◯ Other: ◯ Extracted DNA & DNA Source: (Blood, Buccal, Tissue, Fibroblast)

I have read the attached Informed Consent document and I give permission to Tesis Labs to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at Tesis Labs and for publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications. More information is available at www.tesislabs.com

☐ Opt out of research

☐ Check this box if you are a New York state resident and give permission for Tesis Labs to retain any remaining sample longer than 60 days after the completion of testing.

PATIENT SIGNATURE (REQUIRED FOR BILLING PURPOSES)	DATE (MM/DD/YYYY)
X	

ORDER PROVIDER

INSTITUTION/PRACTICE NAME	INSTITUTION PHONE/FAX/EMAIL
PROVIDER LAST NAME	PROVIDER FIRST NAME

NPI (USA)	MINC (CANADA)	PROVIDER TITLE (MD, DO, GC)

PROVIDER ADDRESS

CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY

PROVIDER PHONE	FAX REPORT TO
GC/PRIMARY CONTACT	GC/PRIMARY CONTACT PHONE/EMAIL/FAX

I attest that the patient has received and read the Tesis Labs Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any Tesis labs Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

STATEMENT OF MEDICAL NECESSITY

By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

ORDERING PROVIDER SIGNATURE (REQUIRED)	DATE (MM/DD/YYYY)
X	

TEST REQUESTED

◯ Beacon ACOG/ACMG ◯ Beacon Expanded ◉ Beacon Expanded + Opt-In ◯ Beacon Custom (Specify genes. Use separate page if necessary.)

◯ Beacon Focus ◯ Beacon Ashkenazi Jewish

Appropriate panel will be selected based on patient sex.

Merged Couple Report

This section must be completed for a merged couple report

Please note:

- If not signed by the partner, separate reports will be issued.
- By signing, the partner will be consenting to genetic testing as described above, and authorizing the release of their results to the patient's healthcare provider, which may include sensitive medical information. The results will become part of the patient's medical record, which is available to the patient's physician and other covered entities.
- Merged couples reports can only be produced for patients and partners that have ordered the same test. If tests do not match individual reports will be produced.
- Partner's sample is not needed if they have been previously tested at Tesis Labs and has a Tesis Labs Accession ID. This can be found on the top of a report.
- Please note that if the partner's sample is not sent together and no Tesis Labs Accession ID is specified, individual reports will be produced. It is possible to call Tesis Labs and obtain the Tesis Labs AccessionID of recently submitted tests that have not been reported at the time of a partner requisition.

LAST NAME	FIRST NAME
GENETIC SEX ◯ Male ◯ Female ◯ Unknown	ETHNICITY
DATE OF BIRTH (MM/DD/YYYY)	Tesis Labs ACCESSION ID
SAMPLE DRAW DATE (MM/DD/YYYY)	SAMPLE TYPE ◯ Blood ◯ Buccal ◯ Other: ◯ Extracted DNA & DNA Source: (Blood, Buccal, Tissue, Fibroblast)
PATIENT SIGNATURE (REQUIRED) X	DATE (MM/DD/YYYY)

INDICATIONS FOR TESTING

Check all that apply.

☐ Patient Screening
☐ Partner Screening
☐ Pregnancy
☐ Family History
☐ Infertility
☐ Egg/Sperm Donor
☐ Other:

DUE DATE IF PREGNANT (MM/DD/YYYY)

ULTRASOUND FINDINGS/ CLINICAL TESTING

INSURANCE BILLING

Attach front and back of all insurance cards, ABN, medical criteria form

PLEASE ATTACH INSURANCE CARDS FOR BILLING	ICD-10 VALID CODE	REFERRAL/PRIOR AUTH	Tesis Labs BENEFITS ID #	By signing above, the patient or insured authorizes Tesis Labs to release medical information concerning the test to the assigned insurance company.

PRIMARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)
SECONDARY INSURANCE ID	INSURANCE NAME	STATE	GROUP	INSURANCE PHONE #
INSURANCE PLAN	NAME OF INSURED		RELATION TO PATIENT	DATE OF BIRTH (MM/DD/YYYY)

INSTITUTIONAL BILLING

INSTITUTION/PRACTICE NAME

ATTENTION TO

ADDRESS

CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY

PHONE	FAX/EMAIL

SELF PAY

◯ Use patient information above for billing
◯ Use information below for billing

By signing above, the patient or payor authorizes Tesis Labs to contact them directly, and use the provided billing instructions to bill the indicated method.

PAYOR LAST NAME	PAYOR FIRST NAME

ADDRESS

CITY	STATE/PROVINCE	POSTAL CODE	COUNTRY

PHONE	FAX/EMAIL

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CLINICAL HISTORY

Attach any available detailed medical records and clinical notes

Clinical Details

Check all that apply:

- ☐ Mosaicism
- ☐ Bone Marrow Transplant
- ☐ Known Chromosomal Gain/Loss
- ☐ Consanguinity
- ☐ Organ Transplant
- ☐ Known Gene Gain/Loss

There are many factors which may affect genetic diagnostic testing: such as gene-gene interactions, high-risk ethnicity groups, and transplants. Please list any that may apply. For additional details, please see the Tesis Labs website.

Please specify any that are checked above:

FAMILY HISTORY

Attach pedigree and additional pages as needed

FAMILY MEMBER 1 NAME	RELATION TO PATIENT	GENETIC SEX ◯ Male ◯ Female ◯ Unknown	
DIAGNOSIS AND/OR SYMPTOMS		AGE OF ONSET	DOB (MM/DD/YYYY)
FAMILY MEMBER 2 NAME	RELATION TO PATIENT	GENETIC SEX ◯ Male ◯ Female ◯ Unknown	
DIAGNOSIS AND/OR SYMPTOMS		AGE OF ONSET	DOB (MM/DD/YYYY)
FAMILY MEMBER 3 NAME	RELATION TO PATIENT	GENETIC SEX ◯ Male ◯ Female ◯ Unknown	
DIAGNOSIS AND/OR SYMPTOMS		AGE OF ONSET	DOB (MM/DD/YYYY)

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INSTRUCTIONS

1. Complete the patient and provider information section.
2. Read and sign the informed consent policy statement. The complete patient informed consent form for genetic testing can be found on Tesislabs.com. Signature from the provider on Page 1 of the TRF is required for all testing. Signature from the primary patient is only required for billing purposes.
3. Select the test and indicate any relevant test options. Please call us if you have any questions.
4. Merged couple reports will only be produced if the the partner's sample, information, and consent to testing is submitted with the primary patient's sample and TRF.
5. Please visit tesislabs.com for specimen requirements.
   Extracted DNA must extracted from a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by CAP and/or CMS.

REQUIRED FOR INSURANCE CHECKLIST

- ☐ Detailed medical record (pedigree if available)
- ☐ ICD-10 codes(s)
- ☐ Physician, patient, and insured signatures
- ☐ Copy of insurance card(s) - front/back
- ☐ Insurer specific forms (i.e. ABN)
- ☐ Insurance authorization, if available
- ☐ For medicare, medicare criteria form is required