TEST REQUISITION FORM

# Beacon Carrier Screening

## PATIENT INFORMATION *

LAST NAME* | FIRST NAME*

SEX AT BIRTH* | DATE OF BIRTH (DD/MONTH/YYYY)* | ETHNICITY

ADDRESS*

SUBURB* | STATE* | POSTAL CODE* | COUNTRY*

PHONE* | EMAIL*

MEDICARE NO. | REFERENCE NUMBER | EXPIRY

## PARTNER INFORMATION (merged couple report only+)

LAST NAME* | FIRST NAME*

SEX AT BIRTH* | DATE OF BIRTH (DD/MONTH/YYYY)* | ETHNICITY

ADDRESS*

SUBURB* | STATE* | POSTAL CODE* | COUNTRY*

PHONE* | EMAIL*

MEDICARE NO. | REFERENCE NUMBER | EXPIRY

***PATIENT ACKNOWLEDGEMENT***

*I confirm that I have been informed about the details of the Fulgent Beacon Carrier Screen test, including the purpose, capabilities, and limitations of the ordered test. I have read the Informed Consent document and I give permission to Fulgent Genetics and its entities to perform genetic testing as described.*

***Medicare Assignment:*** *I understand that I am free to choose my own pathology provider. I confirm that my doctor has recommended that I use Fulgent Australia, and when a particular pathology practitioner is specified on clinical grounds, a Medicare rebate will only be payable if that pathology practitioner performs the service. I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner pursuant to Section 20A of the Health Insurance Act 1973 (Cth).*

***Financial Consent:*** *I understand and agree to pay an out-of-pocket cost if I do not qualify for a Medicare rebate for this test, or if the test is not bulk billed and there is a fee in addition to the Medicare rebate. I understand that a cancellation fee may apply if I choose not to proceed with testing. Where applicable, I agree to pay the account in full prior to testing commencing. I understand that failure to do so could result in delays in testing.*

***Privacy Policy:*** *The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update enrolment records. Its collection is authorised by the provisions of the Health Insurance Act 1973. The information may be disclosed to the Department of Health and Aged Care or to a person in the medical practice associated with this claim, or as authorised/required by law. More information is available at https://fulgentgenetics.com.au/policies/privacy-policy.*

***Research Consent:*** *I give permission for my specimen and clinical information to be used in de-identified studies at Fulgent 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.*

***Reporting Consent:*** *Fulgent Genetics and its entities may email my test results to my requesting doctor using standard TLS encryption.*

☐ Opt out of research ☑ This test was performed as an out of hospital service

X _____ Patient Signature (Required)* _____ Date (DD/MONTH/YYYY)

☐ Opt out of research ☑ This test was performed as an out of hospital service

X _____ Partner Signature+ (Required)* _____ Date (DD/MONTH/YYYY)

## PATIENT SAMPLE

SAMPLE COLLECTION DATE / TIME (DD/MONTH/YYYY, 24HR) | SAMPLE TYPE ☐ Buccal/saliva ☐ Blood (EDTA) ☐ Other:

*I certify that I confirmed the identity of this patient, collected the specimen at the indicated date and time, and labelled the specimen with the patient's name and DOB.*

Collector's Name* | X Collector's Signature (Required)*

## PARTNER SAMPLE (merged couple report only+)

SAMPLE COLLECTION DATE / TIME (DD/MONTH/YYYY, 24HR) | SAMPLE TYPE ☐ Buccal/saliva ☐ Blood (EDTA) ☐ Other:

*I certify that I confirmed the identity of this patient, collected the specimen at the indicated date and time, and labelled the specimen with the patient's name and DOB.*

Collector's Name* | X Collector's Signature (Required)*

## REQUESTING DOCTOR

INSTITUTION NAME / CLIENT ID*

ADDRESS

REPORTING METHOD* (provide email or fax number) | PREFERRED CONTACT INFO (provide email or phone number)

NAME* | PROVIDER NUMBER*

*I attest that the patient(s) have been fully informed about the purpose, capabilities, and limitations of the ordered test. The patient(s) have voluntarily given their full consent for the ordered test. For Expanded Carrier Screening, a signed copy of this consent is available on the patient's medical record.*

X _____ Requesting Doctor's Signature (Required) * _____ Date (DD/MONTH/YYYY)*

## TEST REQUESTED *

- ○ Beacon 3-Gene (CF, SMA and FXS) — Medicare Item No: 73451, 73452
- ○ Beacon 3-Gene Plus (CF, SMA, FXS plus X-linked) — Medicare Item No: 73451
- ○ Beacon Expanded (Individual) § — Not eligible for Medicare rebate
- ○ Beacon Expanded (Merged Couple)+ § — Not eligible for Medicare rebate
- ○ Beacon Custom (provide gene list on the next page) § — Not eligible for Medicare rebate

X-linked genes are not routinely analysed for male carrier screening tests. The appropriate panel will be selected based on the patient sex at birth provided above.
§ Beacon Expanded and Custom testing is performed by Fulgent Genetics in California, USA.

## BILLING TYPE *

☐ Patient self-pay (invoice will be sent to the primary patient) ☐ Medicare ☐ Institutional pay (please complete billing information on the next page)

TEST REQUISITION FORM

# Beacon Carrier Screening

## INSTITUTIONAL BILLING INFORMATION

INSTITUTION / CLIENT ID* | ATTENTION TO | ADDRESS*

PHONE | EMAIL* | SUBURB | STATE | POSTAL CODE | COUNTRY

## BEACON PANEL CUSTOMISATION

Indicate panel customisations here, or attach the desired gene list. Only genes included in the Beacon 787 Expanded panel can be tested.
For Medicare-rebated testing, only genes included in the Beacon 3-Gene Plus panel can be tested.
The current gene list can be found at: www.fulgentgenetics.com.au/reproductive/beacon-carrier-screening/panels.

## INDICATIONS FOR TESTING

Check all that apply.

☐ Planned Pregnancy ☐ Pregnant ☐ Family History
☐ Partner Screening ☐ Infertility ☐ Egg/Sperm Donor
☐ Other _____

DUE DATE IF PREGNANT (DD/MONTH/YYYY)

ULTRASOUND FINDINGS/ CLINICAL TESTING

## CLINICAL HISTORY

Check all that apply.

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

Please specify any that are checked:

## FAMILY HISTORY

Attach pedigree and additional pages as needed

| | | |
|---|---|---|
| FAMILY MEMBER NAME (1) | RELATION TO PATIENT | SEX AT BIRTH ○ Male ○ Female ○ Unknown |
| DIAGNOSIS AND/OR SYMPTOMS | AGE OF ONSET | DATE OF BIRTH (DD/MONTH/YYYY) |
| FAMILY MEMBER NAME (2) | RELATION TO PATIENT | SEX AT BIRTH ○ Male ○ Female ○ Unknown |
| DIAGNOSIS AND/OR SYMPTOMS | AGE OF ONSET | DATE OF BIRTH (DD/MONTH/YYYY) |
| FAMILY MEMBER NAME (3) | RELATION TO PATIENT | SEX AT BIRTH ○ Male ○ Female ○ Unknown |
| DIAGNOSIS AND/OR SYMPTOMS | AGE OF ONSET | DATE OF BIRTH (DD/MONTH/YYYY) |

***Merged Couple Report**

- By signing this form, both the patient and partner are consenting to genetic testing as described above and authorising the release of their results, which may include sensitive medical information, to each others' healthcare provider(s). The test results may become part of each others' medical records.
- The below criteria are required for Fulgent to issue a merged couple report. If these criteria are not met, then separate individual reports will be issued for the patient and partner.
  - This form must be signed by both the patient and the partner.
  - The same corresponding tests must be ordered for both the patient and the partner.
  - This form, the patient's sample, and the partner's sample must all be sent together. Alternatively, if Fulgent is already in possession of the patient or partner's sample, that sample's Fulgent Accession ID must be specified on this form.
    - The Fulgent Accession ID can be found on the top of a Fulgent test report. For tests that have not been reported yet, it is possible to contact Fulgent to obtain the Fulgent Accession ID.



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