TEST REQUISITION FORM

Beacon Carrier Screening

CLIENT NAME/ID (FOR LAB USE): _____

*Highlighted fields are required information

PATIENT INFORMATION

LAST NAME* | FIRST NAME*

SEX ASSIGNED AT BIRTH ○ Male ○ Female ○ Unknown | DATE OF BIRTH (MM/DD/YYYY)*

MRN | ETHNICITY

ADDRESS

CITY | STATE | POSTAL CODE | COUNTRY

PHONE | EMAIL

SAMPLE DRAW COLLECTION DATE* (MM/DD/YYYY)

SAMPLE TYPE*: ○ Blood ○ Buccal/Saliva

○ Extracted DNA & DNA Source (Blood, Buccal/Saliva, Tissue, Fibroblast): _____ ○ Other: _____

PATIENT ACKNOWLEDGEMENT

I have read the Informed Consent document and I give permission to Fulgent Genetics and its entities to perform genetic testing as described. I also 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.

More information is available at www.fulgentgenetics.com/policies/privacy-policy.

☐ Check this box if you are a New York state resident and give permission for Fulgent to retain any remaining sample longer than 60 days after sample collection.

☐ Opt out of research

X _____ _____

Patient Signature (Required for billing purposes) | Date (MM/DD/YYYY)

ORDERING PROVIDER

INSTITUTION/PRACTICE NAME

INSTITUTION PHONE / FAX | INSTITUTION EMAIL

ORDERING PROVIDER(S)

NPI (USA) / MINC (Canada) | PROVIDER TITLE (MD, DO, GC)

PROVIDER ADDRESS

CITY | STATE | POSTAL CODE | COUNTRY

PROVIDER PHONE | FAX/EMAIL REPORT TO

GC/PRIMARY CONTACT NAME

GC/PRIMARY CONTACT PHONE/FAX | GC/PRIMARY CONTACT EMAIL

STATEMENT OF INFORMED CONSENT

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.

I attest that the patient has received and read the Fulgent Informed Consent document, or has had it read to them, 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 Fulgent Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

X _____ _____

Ordering Provider Signature (Required)* | Date (MM/DD/YYYY)

TEST REQUESTED

- ○ **Beacon Core Guidelines Carrier Screening - With XL Disorders** (FT-TP01005)
- ○ **Beacon Core Guidelines Carrier Screening - No XL Disorders** (FT-TP01010)
- ○ **Beacon High Frequency Carrier Screening - With XL Disorders** (FT-TP01438)
- ○ **Beacon High Frequency Carrier Screening – No XL Disorders** (FT-TP01439)
- ○ **Beacon Expanded Carrier Screening - With XL Disorders** (FT-TP01007)
- ○ **Beacon Expanded Carrier Screening - No XL Disorders** (FT-TP01012)
- ○ **Beacon Expanded Carrrier Screening Plus - With XL Disorders** (FT-TP01008)
- ○ **Beacon Expanded Carrier Screening Plus - No XL Disorders** (FT-TP01013)
- ○ **Beacon 787-Expanded Carrier Screening – With XL Disorders** (FT-TP01712)
- ○ **Beacon 787-Expanded Carrier Screening – No XL Disorders** (FT-TP01713)
- ○ **Beacon Custom Carrier Screening** (FT-TP01014)

Specify genes. Use separate page if necessary.

Note: X-linked genes are not routinely analyzed for carrier screens when sex assigned at birth is male.

INDICATIONS FOR TESTING (Check all that apply)

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

Due Date if Pregnant (MM/DD/YYYY): _____

Ultrasound Findings/Clinical Testing: _____

PATIENT COMMUNICATION CONSENT

☐ By checking this box, you acknowledge and agree that:

a. By executing this agreement, you are providing express written consent for Fulgent, CSI, and Inform Diagnostics, their affiliates and subsidiaries, and parties making contact on their behalf to call and text you using automatic telephone dialing systems and artificial or pre-recorded messages at the telephone number you have provided, about your out-of-pocket estimation, even if your telephone number is currently listed on any state, federal, local or corporate Do Not Call list.

b. Your Consent to be contacted through the use of automatic telephone dialing systems and artificial or pre-recorded messages is not required in order to purchase any property, goods, or services. If you would like to speak with our Benefits Investigation team, you can reach them at **+1 888.FULGENT (+1 888.385.4368), opt 3**.

CLINICAL DETAILS

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 Fulgent website.

☐ Consanguinity
☐ Bone Marrow Transplant/ Organ Transplant
☐ Known Mutations
☐ Mosaicism

Please specify relevant clinical and family history:

4399 Santa Anita Ave., El Monte, CA 91731 | www.FulgentGenetics.com | info@fulgentgenetics.com | **P** +1 626.350.0537 | **F** +1 626.454.1667

 | CLIA 05D2043189 | D# TRF-Beacon Carrier Screening Consent-V5

TEST REQUISITION FORM

Beacon Carrier Screening

MERGED COUPLE REPORT

LAST NAME | FIRST NAME

SEX ASSIGNED AT BIRTH | DATE OF BIRTH (MM/DD/YYYY)

○ Male ○ Female ○ Unknown

FULGENT ACCESSION ID | ETHNICITY

SAMPLE DRAW COLLECTION DATE (MM/DD/YYYY)

SAMPLE TYPE: ○ Blood ○ Buccal/Saliva

○ Extracted DNA & DNA Source (Blood, Buccal/Saliva, Tissue, Fibroblast): _____ ○ Other: _____

PATIENT ACKNOWLEDGEMENT

I have read the Informed Consent document and I give permission to Fulgent Genetics and its entities to perform genetic testing as described. I also 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. More information is available at www.fulgentgenetics.com/policies/privacy-policy.

☐ Check this box if you are a New York state resident and give permission for Fulgent to retain any remaining sample longer than 60 days after sample collection.

☐ Opt out of research

X _____ _____

Patient Signature (Required for billing purposes) Date (MM/DD/YYYY)

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 Fulgent and has a Fulgent 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 Fulgent Accession ID is specified, individual reports will be produced. It is possible to call Fulgent and obtain the Fulgent Accession ID of recently submitted tests that have not been reported at the time of a partner requisition.

BILLING OPTIONS

Please select a billing option and complete the relevant fields below: ○ Insurance ○ Institution ○ Self-Pay

INSURANCE/BILLING INFORMATION

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

By signing above, the patient or payor authorizes Fulgent and its entities to contact them directly (including via text), and authorizes Fulgent and its entities to release medical information concerning the test to the assigned insurance company.

ICD-10 VALID CODE | REFERRAL/PRIOR AUTH | FULGENT BENEFITS ID#

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 ID | NAME OF INSURED | RELATION TO PATIENT | DATE OF BIRTH (MM/DD/YYYY)

INSTITUTIONAL BILLING

○ Use institution information above for billing
○ Use information below for billing

INSTITUTION/PRACTICE NAME | ATTENTION TO

ADDRESS

CITY | STATE | POSTAL CODE | COUNTRY

PHONE | EMAIL

SELF-PAY

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

○ Use patient information above for billing
○ Use information below for billing

PAYOR LAST NAME | PAYOR FIRST NAME

ADDRESS

CITY | STATE | POSTAL CODE | COUNTRY

PHONE | EMAIL

4399 Santa Anita Ave., El Monte, CA 91731 | www.FulgentGenetics.com | info@fulgentgenetics.com | **P** +1 626.350.0537 | **F** +1 626.454.1667

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