LCA Use Only. Please place accessioning sticker here.

Clinical Questionnaire for **Reveal® SNP Microarray - Pediatric**

This form should be completed when Reveal® SNP Microarray - Pediatric testing is ordered. The form should be completed by the ordering physician's office and should accompany the sample. Please call 800-345-GENE (4363) and ask to speak to a cytogenetics genetic counselor with any questions.

Patients name: ______________________ Date of birth: ______________________

Gender: ❍ Male ❍ Female Name of person completing form: ______________________

Primary Diagnosis

Development (any delays): ______________________

Cognitive: ______________________ ❍ Suspect autism spectrum disorder

Motor (gross): ______________________ (fine motor): ______________________

Growth (delays/overgrowth, etc): ______________________

Other: ______________________

Any dysmorphic features (unusual facial characteristics): ______________________

Review of Systems (please comment on any issues/problems/abnormal studies associated with each system)

Neurological/Mental: ______________________

Chest/Lungs: ______________________

Heart: ______________________

Genital/Urinary: ______________________

Skeletal/Liimbs: ______________________

Eyes/Skin: ______________________

Other: ______________________

Prenatal History

Any signficant prenatal history: ______________________

Abnormal labs: ______________________

Chromosome analysis results: ______________________ Year performed?" ____________

Significant Family History

❍ Unknown or limited family history? Please explain (eg, adopted) ______________________

Relative*	Maternal / Paternal	Condition/Clinical Diagnosis/Previous Genetic Test Results	Has genetic testing been performed? If yes, attach lab report.
	❑ / ❑		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No

Are the parents related (other than by marriage, for example first or second cousins)? If so, how?: ______________________

Ordering provider understands by signing below:
Pretest counseling, which includes an interpretation of family and medical histories; education about inheritance, genetic testing, disease management, prevention, and resources; counseling to promote informed choices and adaptation to the risk or presence of a genetic condition; and counseling for the psychological aspects of genetic testing, has been completed where required by health plan. Post-test counseling will be available.

Account No.: ______________________

Provider Name (print): ______________________ NPI: ____________

Provider Phone No.: ______________________ Fax No.: ____________

______________________ / ____________
Ordering Provider Signature **Date**

Patient understands by signing below:
LabCorp may use information obtained on this form and other information provided by me and/or my ordering provider or his/her designee to initiate prior authorization with my health plan as required. I understand a prior authorization approval from my health plan does not guarantee full payment. It is my responsibility to contact my health plan regarding concerns over my coverage and benefits.

____
Patient Signature

____
Date

www.LabCorp.com

Additional copies of this form can be printed from our website: www.integratedgenetics.com.

LabCorp Specialty Testing Group

©2020 Laboratory Corporation of America® Holdings All rights reserved. rep-443-v3-0520 / L22400-0520-3