



Please place green collection kit barcode here.

Phone: 800-298-6470 / Fax: 646-859-6870
 Branford CT Lic#: CL-0830
 Stamford CT Lic#: CL-1016

Please fill out all the highlighted fields. Failure to do so may result in delayed testing and delivery of results.

PATIENT INFORMATION

Sema4 will use this information to contact the patient via automatic email, SMS, and/or phone regarding payment, testing status, and online results access. By submitting this requisition, I confirm that I have obtained the patient's authorization to be contacted by Sema4 by these means (email address must be specific to patient listed on form).

PATIENT EMAIL ADDRESS	PATIENT MOBILE/PRIMARY NUMBER
LAST NAME	FIRST NAME MI
DATE OF BIRTH	SEX ASSIGNED AT BIRTH
CLIENT MRN	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> INTERSEX
ADDRESS	CITY / STATE / ZIP

BILLING INFORMATION

Bill to: Insurance (Provide ICD10 in Indications for Testing) Client/Institution Self Pay/No Insurance

POLICYHOLDER LAST NAME	POLICYHOLDER FIRST NAME	POLICYHOLDER DOB
INSURANCE CARRIER	INSURANCE ID	GROUP NO.
BILLING ADDRESS		
SECONDARY INSURANCE	<input type="checkbox"/> YES <input type="checkbox"/> NO	
SECONDARY INSURANCE NAME	GROUP NO.	

Pre-Authorization #: _____ Please include a copy of all insurance paperwork.

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the provider and I understand that I am financially responsible for uncovered services. I also authorize the release of any information required to process the claim. Billing inquiries, please call 800-298-6470.

SIGNATURE _____ DATE MM / DD / YYYY

ORDERING PROVIDER INFORMATION

NAME	GENETIC COUNSELOR
ADDRESS	CLINIC / INSTITUTION
	TELEPHONE
	FAX

PROVIDER SIGNATURE OF CONSENT (REQUIRED): I certify that this patient (and/or their legal guardian, as necessary) has been informed of the benefits, risks, and limitations of the laboratory test(s) requested. I have answered this person's questions. I have obtained a signed informed consent from this patient or their legal guardian for this testing in accordance with applicable laws and regulations, including N.Y. Civil Rights Law Section 79-L, and will retain this consent in the patient's medical record.

SIGNATURE _____ DATE MM / DD / YYYY

CLINICAL INDICATION (PLEASE FILL OUT ADDITIONAL INDICATIONS ON BACK)

SPECIMEN TYPE:
 For Aminolevulinic Acid, Porphobilinogen, and Tamoxifen Metabolites, specimen should be protected from light
 Blood Plasma Serum DBS Urine CSF Other _____

COLLECTION DATE MM / DD / YYYY COLLECTION TIME: ____: ____ AM/PM

CLINICAL INFORMATION: Please provide relevant clinical history information/records

PLEASE PROVIDE ICD10(s) HERE

LABORATORY TESTING INFORMATION

History of bone marrow transplant? YES NO History of recent blood transfusion within the last 4 weeks? YES NO **Note: If Yes, please contact Sema4 to confirm if an alternate specimen is needed for testing.**

LABORATORY TEST(S) ORDERED

Analyte Testing

TEST CODE	TEST NAME	SAMPLE TYPE
<input type="checkbox"/> AACSF	Amino Acids Full Panel, CSF	CSF
<input type="checkbox"/> AAPL	Amino Acids Full Panel, Plasma	Plasma
<input type="checkbox"/> AAUR	Amino Acids Full Panel, Urine	Urine
<input type="checkbox"/> SAA	Amino Acids Selective Panel (PKU/MSUD)	Plasma
<input type="checkbox"/> PKU	Phenylalanine/Tyrosine	DBS
<input type="checkbox"/> ACD	Acylcarnitine Profile, DBS	DBS
<input type="checkbox"/> ACP	Acylcarnitine Profile, Plasma	Plasma
<input type="checkbox"/> CARN	Carnitine Concentration, Plasma/Serum	Plasma/Serum
<input type="checkbox"/> CARU	Carnitine Concentration, Urine	Urine
<input type="checkbox"/> UOA	Organic Acids	Urine
<input type="checkbox"/> MMAPL	Methylmalonic Acid, Plasma	Plasma
<input type="checkbox"/> MMAUR	Methylmalonic Acid, Urine	Urine
<input type="checkbox"/> ORO	Orotic Acid	Urine
<input type="checkbox"/> SUCC	Succinylacetone	Urine

Biomarkers for LSD

TEST CODE	TEST NAME	SAMPLE TYPE
<input type="checkbox"/> CHITO	Chitotriosidase activity (Gaucher Disease)	Plasma
<input type="checkbox"/> LGL1	Lyso-GL1 (Gaucher Disease)	Plasma
<input type="checkbox"/> LGB3	Lyso-Gb3 (Fabry Disease)	Plasma
<input type="checkbox"/> LSPM	Lyso-SPM (Niemann-Pick Disease)	Plasma
<input type="checkbox"/> PSYC	Psychosine (Krabbe Disease)	Plasma
<input type="checkbox"/> GAG	Quantitative GAG (DS, HS, CS)	Urine
<input type="checkbox"/> KSU	Quantitative GAG (KS)	Urine

Congenital Disorders of Glycosylation (CDG)

TEST CODE	TEST NAME	SAMPLE TYPE
<input type="checkbox"/> CDT	Carbohydrate Deficient Transferrin	Plasma
<input type="checkbox"/> NGLY	N-Glycan Profiling	Plasma
<input type="checkbox"/> OGLY	O-Glycan Analysis	Plasma

Porphyria Analytes

TEST CODE	TEST NAME	SAMPLE TYPE
<input type="checkbox"/> ALAU	Aminolevulinic Acid (ALA), Urine	Urine
<input type="checkbox"/> ALAP	Aminolevulinic Acid (ALA), Plasma	Plasma
<input type="checkbox"/> PBGU	Porphobilinogen (PBG), Urine	Urine
<input type="checkbox"/> PBGP	Porphobilinogen (PBG), Plasma	Plasma
<input type="checkbox"/> UPP	Aminolevulinic Acid/Porphobilinogen	Urine
<input type="checkbox"/> PPP	Aminolevulinic Acid/Porphobilinogen	Plasma

LSD Enzyme Testing

TEST CODE	TEST NAME	SAMPLE TYPE
<input type="checkbox"/> ASM	Acid Sphingomyelinase (Niemann-Pick A/B)	Blood
<input type="checkbox"/> GDSCRN	Acid-β-Glucosidase (Gaucher Disease)	Blood
<input type="checkbox"/> LAL	Lysosomal Acid Lipase (Wolman/Cholesteryl Ester Storage Disease)	Blood
<input type="checkbox"/> FABRY	α-Galactosidase A (Fabry Disease)	Blood
<input type="checkbox"/> GAA	Acid α-Glucosidase (Pompe disease)	Blood
<input type="checkbox"/> IDUA	α-L-Iduronidase (MPS-I)	Blood
<input type="checkbox"/> GALC	β-Galactocerebrosidase (Krabbe Disease)	Blood
<input type="checkbox"/> TAYSAC	Hexosaminidase A (Tay-Sachs Disease)	Blood
<input type="checkbox"/> SANDHO	Hexosaminidase B (Sandhoff Disease)	Blood

Pharmacogenetic Testing

TEST CODE	TEST NAME	SAMPLE TYPE
<input type="checkbox"/> TAM	Tamoxifen Metabolites Profiling	Plasma

**Patient must be on standard dose (20 mg/day) of Tam for at least 3 months prior to testing or until the steady state is ready.*

Porphyria Molecular Testing

TEST CODE	PANEL NAME	GENE
<input type="checkbox"/> APP	Porphyria Acute Panel	HBMS, CPOX, PPOX
<input type="checkbox"/> CPP	Porphyria Cutaneous Panel	CEP, EPP, PCT
<input type="checkbox"/> POR	Acute Intermittent Porphyria	HBMS
<input type="checkbox"/> POR	Hereditary Coproporphyria	CPOX

Porphyria Molecular Testing (cont)

TEST CODE	TEST/PANEL NAME	GENE
<input type="checkbox"/> POR	Variegate Porphyria	PPOX
<input type="checkbox"/> POR	Congenital Erythropoietic Porphyria	UROX, ALAS*
<input type="checkbox"/> POR	Familial Porphyria Cutanea Tarda	UROD
<input type="checkbox"/> POR	Erythropoietic Protoporphyrria Panel	FECH, ALAS*
<input type="checkbox"/> POR	Porphyria Associated Kidney Disease	SLC15A2^
<input type="checkbox"/> POR	PEPT2 Genotyping	

LSD Molecular Testing

TEST CODE	TEST NAME	GENE
<input type="checkbox"/> DSGSV2	Niemann Pick A/B	SMPD1
<input type="checkbox"/> DSGSV2	Gaucher Disease	GBA
<input type="checkbox"/> DSGSV2	Wolman/Cholesteryl Ester Storage Disease	LIPA
<input type="checkbox"/> DSGSV2	Fabry Disease	GLA
<input type="checkbox"/> DSGSV2	Pompe disease	GAA
<input type="checkbox"/> DSGSV2	Mucopolysaccharidosis type 1	IDUA
<input type="checkbox"/> DSGSV2	Krabbe Disease	GALC
<input type="checkbox"/> DSGSV2	Tay-Sachs Disease	HEXA
<input type="checkbox"/> DSGSV2	Sandhoff Disease	HEXB
<input type="checkbox"/> CHITO	Chitotriosidase	CHIT1
<input type="checkbox"/> CUSTPGX	CYP2D6 Genotyping	CYP2D6

Molecular Diagnostic Testing

Gene(s): _____

TEST CODE	TEST NAME
<input type="checkbox"/> DSGSV2	Custom Diagnostic Gene Sequencing
<input type="checkbox"/> TARG	Targeted Mutation Analysis (assessment for a known familial variant)

Variant(s): _____
 Was this relative's variant(s) identified at Sema4?
 No - Please attach a copy of the relative's test report (required)
 Yes - Sema4 ID: _____
 Name: _____
 Date of Birth: _____
 Patient's relationship to relative: _____

PATIENT NAME	DATE OF BIRTH	PHYSICIAN NAME	PRACTICE NAME
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Please submit separate signed general consent form for each sample submitted (including parents)

Informed Consent for Genetic Testing

If you do not have legal authority and capacity to sign this consent under law, a legal representative who has the legal authority and capacity to do so must sign this consent and authorization on your behalf.

I hereby request the genetic testing ordered by my health care provider, which may include molecular, cytogenetic, and/or biochemical analyses of my sample(s). I have received information (please see www.sema4.com/testcatalog for test-specific information sheet) from my physician or from a genetic counselor that described, in words that I understand, the nature of the genetic testing that I am about to undergo.

I understand that specimen(s), such as a peripheral blood, saliva, cheek swab, dried blood spot, skin biopsy, amniotic fluid, chorionic villus, and/or urine sample, will be taken from me. I understand that these samples will be used for determining if I have a genetic disease, am a carrier of a genetic disease, or am more likely to develop a genetic disease or condition.

The nature of the genetic test(s) ordered in connection with this consent has been explained to me, and the accuracy of the test and its risks and limitations have been detailed. I understand that infrequent errors may occur, even though the likelihood of an incorrect diagnosis or a misinterpretation of the result is extremely small. I understand that a negative result reduces, but does not eliminate, the possibility that I carry a variant(s) in the gene(s) analyzed. It does not change the possibility that I carry a variant(s) in other genes that are not included in the test. I understand that a positive result is an indication that I may be predisposed to or have a specific disease or condition and I may consider further independent testing, consult my physician, or pursue genetic counseling. Knowledge of genetic information will improve over time and new information may become available in the future that could impact the interpretation of my results.

I understand that test results may reveal incidental, unsought information, such as discovering an undiagnosed disorder. I understand that this testing may yield results that are of unknown clinical significance and that parental or other relative's specimens may also be tested to determine whether a specific finding was inherited. This testing may reveal cases of adoption or demonstrate that a person is not the biological father or mother of the patient. An error in the diagnosis may occur if the true biological relationships of the family members involved are not as I have described.

For a test that requires Sema4 to evaluate my results in the context of clinical information from one or more of my family members and/or my reproductive partner, I understand that Sema4 may disclose my and each of my family members' and/or reproductive partner's clinical information to all tested individuals and our healthcare providers, including in a single comprehensive report, in genetic counseling sessions (if applicable), and consult notes from these sessions, for treatment purposes. I confirm that each person being tested or receiving counseling is aware of the potential for these disclosures.

I understand that the results of this testing will become part of my medical record and may only be disclosed to individuals who have legal access to this record or to individuals I designate to receive this information. My test results will be explained to me by a genetic counselor or by my healthcare provider, who will have the opportunity to discuss my results with a geneticist. There are federal and state laws that address genetic discrimination. The US Genetic Information Nondiscrimination Act may prohibit discrimination based on genetic information by employers and health insurers. This law, however, does not protect people in the military nor protect against discrimination by other types of insurance, such as life, disability, or long-term care insurance. Please note that Sema4 labs are CLIA-approved and accredited by the CAP. Sema4 is a covered entity under HIPAA. I understand that Sema4 is obligated to retain medical records for regulatory purposes and cannot delete my clinical data.

Sema4 may deidentify and retain my left-over sample(s) to use for operational, quality control, validation and improvement purposes, to the extent permitted by law. If I reside in the state of New York, I understand that my sample(s) will not be used for these purposes and will be destroyed no more than 60 days after they were taken or at the end of the testing process, whichever occurs later.

Please complete all required (*) fields and optional applicable fields below:

Patient Name*	Patient's DOB*	Date*
Signature of Patient or Legal Representative*	Email Address*	Phone Number*
Legal Representative Name (if applicable)		

Research using de-identified data

Sema4 may de-identify and use all data and information generated and received in connection with this test to support medical and academic research relating to health, disease prevention, drug development, and other scientific purposes. I will receive no compensation in connection with such research. Data and information are "de-identified" by removing any information that could be used to identify a specific person, such as a name, email address, or date of birth. Sema4 may also give the de-identified data and information to its research partners and may submit it to research databases for use in scientific and medical research. Examples of such research include projects to understand the risk factors and outcomes for various conditions and can be found at www.sema4.com/research.

If I do not want to have my de-identified data and information used in research as set forth above, I may withdraw this consent by following the instructions at www.sema4.com/consent-options/, and I understand that the change will apply to all data generated from tests that I have undergone with Sema4. I further understand that this withdrawal will not apply to any information that has already been de-identified and cannot be identified by Sema4.

Financial Agreement and Guarantee

By my signature on the Sema4 Test Requisition Form or at the bottom of this form, I accept full and complete financial responsibility for all genetic testing ordered by my healthcare provider that is ordered at Sema4. For insurance billing, I authorize Sema4 to bill my health insurance plan on my behalf, to release any information required for billing, and to be my designated representative for purposes of appealing any denial of benefits. I irrevocably assign the payment to Sema4, and direct that payment be made directly to Sema4. I understand that my out-of-pocket costs may be different than the estimated amount indicated to me by Sema4 as part of a benefit investigation. I agree to be financially responsible for all amounts as indicated on the explanation of benefits issued by my health insurance plan. If my insurance provider sends a payment directly to me for unpaid services performed by Sema4 on my behalf, I agree to endorse the insurance check and forward it to Sema4 within 30 days of receipt as payment towards Sema4's claim for services rendered. If I do not have health insurance, I agree to pay for the full cost of the genetic testing that was ordered by my healthcare provider and billed to me by Sema4.

I understand that a completed **Advance Beneficiary Notice (ABN)** is required for **Medicare** patients if the service is deemed non-covered.

Permission to contact

I understand that Sema4 may wish to contact me in the future, including for the following reasons: research purposes, and the provision of general information about research findings. If I wish to opt-out of future contact for research purposes, I will notify Sema4 by following the instructions at www.sema4.com/consent-options/. I understand that Sema4 may contact me regarding this test and/or the provision of information about the results of tests on my sample(s), and I cannot opt out of this type of contact.

My healthcare provider has discussed my test order(s) with me, and I hereby consent to have my specimen tested. I have been encouraged to ask questions and agree that any questions I have asked have been answered to my satisfaction. If my legal representative is signing this consent and authorization, my legal representative is satisfied that they have received enough information to sign on my behalf.

The most updated versions of our consent forms can be found at: <https://sema4.com/resources/>. Further information about managing your privacy options can be found at: <https://sema4.com/consent-options/>.