PRENATAL TESTING REQUISITION

sema4

123456-2-X

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 RECOMMENDED	PATIENT MOBILE/PRIMARY NUMBER REQUIRED	
LAST NAME REQUIRED	FIRST NAME REQUIRED	MI
DATE OF BIRTH MM / DD / YYYY	SEX ASSIGNED AT BIRTH REQUIRED ☐ MALE ☐ FEMALE ☐ INTERSEX	PATIENT IS A SPERM/EGG DONOR ☐ YES ☐ NO
PARTNER / SPOUSE LAST NAME	PARTNER / SPOUSE FIRST NAME	
CLIENT MRN	PARTNER / SPOUSE DATE OF BIRTH MM / DD / YYYY	
ADDRESS REQUIRED	CITY / STATE / ZIP REQUIRED	

ORDERING PHYSICIAN INFORMATION

NAME REQUIRED	GENETIC COUNSELOR
ADDRESS REQUIRED	CLINIC / INSTITUTION REQUIRED
	TELEPHONE
	FAX

PHYSICIAN 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

BILLING INFORMATION

Bill to: ☐ Insurance (Provide required ICD10s for each test below) ☐ Client/Institution ☐ Self Pay/No Insurance

POLICYHOLDER LAST NAME REQUIRED	POLICYHOLDER FIRST NAME REQUIRED	POLICYHOLDER DOB MM / DD / YYYY
INSURANCE CARRIER REQUIRED	INSURANCE ID REQUIRED	GROUP NO. REQUIRED

BILLING ADDRESS REQUIRED

SECONDARY INSURANCE ☐ YES ☐ 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

INDICATIONS FOR TESTING

ICD10 Dx CODE(S) (Required)

Please see each testing section below and write in ICD10s as needed for each test type.

COLLECTION DATE MM/DD/YYYY # OF BLOOD TUBES SENT: YELLOW____ PURPLE____ BCT____ GREEN____

SPECIMEN TYPE: (Please contact laboratory for alternate specimen types)

Maternal: ☐ Peripheral Blood ☐ Saliva ☐ Other_____

Paternal: ☐ Peripheral Blood ☐ Saliva ☐ Other_____

Fetal: ☐ Amniotic Fluid ☐ Chorionic Villi ☐ Other_____

PREGNANCY HISTORY: **Gestational Age:** _____Weeks _____Days *or* EDD: ____/____/____ (Required for fetal samples.)

Pregnancy conceived: ☐ IVF ☐ Egg donor/gestational carrier Age of genetic mother (at time of retrieval):_____

LABORATORY TEST(S) ORDERED

Parental Carrier Screening

Patient ancestry: _____ Preferred Language: _____

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.

Is the patient or their partner pregnant? ☐ YES ☐ NO

Is the patient currently using birth control medication? ☐ YES ☐ NO

Previous carrier screening? ☐ YES ☐ NO

If yes, what gene/variant: _____

Family History of: _____ Partner Carrier of: _____

☐ Standard Pan-ethnic Carrier Screen *(S4) (4 genes)* (**) (includes carrier screening for cystic fibrosis, fragile X syndrome, spinal muscular atrophy, and Smith-Lemli-Opitz syndrome)

Select **BOTH** S4 above and one of the options below to order additional carrier screening:

NEW
- ☐ Expanded Carrier Screen 502 *(S4+498 genes)* (**^)
- ☐ Expanded Carrier Screen 283 *(S4+279 genes)* (**^)
- ☐ High Frequency Pan-ethnic Carrier Screen *(11 genes; S4+7 genes)* (**)
- ☐ Expanded Carrier Screen 39 *(S4+35 genes)* (**^)
- ☐ Expanded Carrier Screen 152 *(S4+148genes)* (**^)
- ☐ Comprehensive Jewish Carrier Screen *(101 genes; S4+97 genes)* (**^)

☐ Supplemental X-linked panel *(32 genes)* (**) (for female patients being screened after their male reproductive partner)

☐ AR disorders partner screened positive for (sample will be held if partner screening has not completed) (**)

☐ Custom Carrier Screen (**) - Please write in each gene that should be screened: Gene(s):_____

☐ Tay-Sachs Enzyme only (^)

☐ Sandhoff Disease Enzyme only (^)

☐ ECS Re-analysis
Previous ECS lab number (required): _____
Note: If a personalized residual risk was not provided with the initial testing this cannot be provided through re-analysis.

☐ Ultra-High Resolution Microarray (targeted follow-up to ECS result) (*) Previous ECS lab number:_____
Gene requiring follow-up: _____

Parental Carrier Screening Indications: ☐ Z31.430 ☐ Z31.440 ☐ Other: _____

Infertility/Pregnancy Loss:

☐ Test for Microdeletions of Y Chromosome (male) (*)

☐ Cystic Fibrosis with *CFTR* Intron 9 PolyT (male) (*)

☐ Thrombophilia Test (3 variants below) (*)
- ☐ F2 - c.*97G>A
- ☐ F5 - c.1601G>A (p.Arg534Gln)
- ☐ *MTHFR* - c.665C>T (p.Ala222Val)

Infertility/Pregnancy Loss Testing Indications
☐ N96 ☐ Z82.7 ☐ N46 ☐ N97 ☐ Other: _____

Noninvasive Prenatal Testing (NIPT) *(Must be at least 9 weeks gestation)*

Sema4 Noninvasive Prenatal Select ☐ Omit fetal sex

- ☐ Standard (chromosomes 13, 18, 21 and Fetal Sex)
  - ☐ With Sex Chromosome Aneuploidies X, XXX, XXY, XYY
- ☐ Standard Plus ("Standard" plus chromosomes 15, 16, 22 and Sex Chromosome Aneuploidies X, XXX, XXY, XYY)
- ☐ Expanded ("Standard Plus" with Microdeletions 22q11.2, 1p36, 4p16, 5p15, 15q11.2-q13, 8q24 and 11q23)

OR

☐ **Sequenom MaterniT GENOME** *Genome-wide fetal aneuploidies (singleton only).*

For multiple gestations, only the Standard Panel is available and the fetal sex will be reported as the presence/absence of the Y chromosome

NIPT REQUIRED CLINICAL INFORMATION Specimen Required: Two 10 mL Whole Blood BCT Streck Tubes

Gestation ☐ Singleton ☐ Twins ☐ Triplets ☐ other _____ (e.g. vanishing twin)
Gestational age: ____Weeks____ Days (at time of collection) or EDD: ____/____/____
Maternal height: _____ ft. _____ in. **Maternal weight**: _____ lbs.
Pregnancy conceived: ☐ IVF ☐ Egg donor/gestational carrier Age of genetic mother (at time of retrieval):_____
If IVF, were multiple embryos transferred? ☐ Yes ☐ No
Is this a repeat test for low fetal fraction? ☐ Yes ☐ No

NIPT MEDICAL INDICATIONS FOR TESTING *Select one or more ICD10 codes*

No known high risk for fetal chromosomal aneuploidies **(Sema4 Noninvasive Prenatal Select only)**
☐ Z34.91 1st tri ☐ Z34.92 2nd tri ☐ Z34.93 3rd tri

High risk for fetal chromosomal aneuploidies

Advanced Maternal age: Primigravida ☐ 009.511 1st tri ☐ 009.512 2nd tri ☐ 009.513 3rd tri; Multigravida ☐ 009.521 1st tri ☐ 009.522 2nd tri ☐ 009.523 3rd tri

Abnormal serum biochemical screening: ☐ 028.1 ☐ DS ☐ Tri 18/13 ☐ AFP

Ultrasound finding: (please specify) ☐ O35.1XX0 _____

Personal/Family History: (please specify) _____

Prior pregnancy with trisomy ☐ 009.291 1st tri ☐ 009.292 2nd tri ☐ 009.293 3rd tri
Translocation/Inversion ☐ Q95.0 ☐ Q95.1

Other high risk factor: (please specify) **ICD10 code** _____

Please contact the laboratory for all prenatal testing

Prenatal Diagnostic Testing

☐ *FGFR3* Hotspot Panel
- ☐ reflex to sequencing if negative

☐ Maternal Cell Contamination

☐ Limb Defects Next Gen Sequencing Panel (7 genes)

☐ Noonan Syndrome Next Gen Sequencing Panel (18 genes)

☐ Prenatal Diagnostic Selective Gene
- ☐ Gene:_____

Please select relevant panel below if gene is not on ECS (please see sema4.com for gene lists on these panels):
- ☐ Custom Hearing and Vision Loss ☐ Custom Cardiovascular
- ☐ Custom Neurodevelopmental ☐ Custom Immunodeficiency
- ☐ Targeted testing: Maternal variant:_____ Paternal variant: _____

Biochemical testing: ☐ Tay-Sachs enzyme analysis ☐ Sandhoff enzyme analysis

- *Maternal blood is required for all prenatal specimens for maternal cell contamination.*
- *If patient/partner was NOT tested at Sema4, parental bloods are required (5-10mL EDTA) to confirm the variant in-house. Please also provide a copy of any previous results.*

For samples received for prenatal molecular and/or biochemical testing, cytogenetic and cytogenomic testing can be ordered in conjunction as shown below. Please note that prenatal diagnostic testing **must be ordered for a sample to be accepted for cytogenetic and cytogenomic testing.**

☐ Chromosome Analysis (includes AFP with amniotic fluid)
- ☐ Reflex to array if normal chromosomes (select option below)

☐ Additional Cell Culture: ☐ Hold ☐ Grow

☐ Mosaicism study

Array Comparative Genomic Hybridization (aCGH) 180K + SNP
Please submit maternal blood (1 EDTA purple top) for Maternal Cell Contamination (MCC) with any microarray order. Please also include blood (1 EDTA and 1 Sodium heparin green top) from parents of the pregnancy for microarray follow up if available.

☐ **Prenatal Chromosomal Microarray** (lower resolution)
☐ **High Resolution Chromosomal Microarray**
☐ **Parental array followup**

Proband SEMA4 Lab ID: _____ Name: _____ DOB: _____

☐ Aneuploidy FISH (chromosomes 13,18,21,X,Y)
☐ FISH other: _____

Prenatal Diagnostic Testing Indications:
☐ 009.511 ☐ 009.512 ☐ N96 ☐ Z82.7 ☐ Z84.81 ☐ 028.3 ☐ 028.5 ☐ Other: _____

LEGEND: ****1 EDTA tube (lavender top)*** ***^1 EDTA tube or 1 ACD tube (yellow top)***
Note: One OGD-500 saliva tube can be substituted for two EDTA tubes. Please note Tay-Sachs Enzyme and Sandhoff Enzyme cannot be performed on a saliva sample.

COMPLETE AND SUBMIT ALL PAGES TO LABORATORY

Available Carrier Screening Genes:

AAAS
ABCA12
ABCA3
ABCA4 ✚
ABCB11
ABCC8 ◆ ● ✠ ▼
ABCD1 ◆ ■ ▼
ACAD9
ACADM ▲ ◆ ● ■ ✠ ▼
ACADS
ACADSB
ACADVL ▼
ACAT1
ACOX1
ACSF3 ▼
ADA ▼
ADAMTS2 ◆ ● ▼
AGA ▼
AGL ◆ ■ ▼
AGPS
AGXT
AIMP1
AIPL1
AIRE ◆ ■ ▼
AKR1D1
ALDH3A2
ALDH7A1
ALDOB ▼
ALG6
ALMS1
ALPL ▼
AMH ✚
AMHR2 ✚
AMN
AMT
ANO5
AP1S1
APOPT1
AQP2
ARG1
ARL6
ARSA ◆ ■ ▼
ARSB
ARSE
ASL ▼
ASNS ◆ ■ ✠ ▼
ASPA ◆ ● ✠ ▼
ASS1 ✠
ATM ◆ ■ ▼
ATP6V1B1 ◆ ■ ▼
ATP7A
ATP7B ◆ ● ■ ▼
ATP8B1
ATRX
AVPR2
BBS1 ▼
BBS10
BBS12
BBS2 ◆ ● ▼
BBS4
BCHE ✚
BCKDHA ✠ ▼
BCKDHB ◆ ● ✠ ▼
BCS1L ▼
BLM ◆ ● ✠ ▼
BMPER
BSND
BTD ▼
BTK
C8ORF37
CANT1
CAPN3
CASQ2
CASR
CBS ▼
CC2D1A
CCDC103
CCDC151
CCDC39
CD3D
CD3E
CD40LG
CD59
CDAN1
CDH23 ▼
CEP152
CEP290 ▼
CERKL ◆ ■ ▼
CFTR ◗ ▲ ◆ ● ■ ✠ ▼
CHAT
CHM
CHRNE
CHRNG
CIITA
CLCNKB
CLN3 ✠
CLN5 ▼
CLN6
CLN8
CLRN1 ◆ ● ▼
CNGA3
CNGB3 ▼
COA7
COL11A2
COL17A1
COL27A1 **NOW INCLUDING Full Gene Sequencing**
COL4A3 ◆ ● ▼
COL4A4
COL4A5
COL7A1 ▼
COQ4
COX10
COX15
COX20
COX6B1
CPS1
CPT1A
CPT2 ◆ ● ▼
CRB1
CTNS ◆ ■ ▼
CTSA
CTSC
CTSK
CYBA ◆ ■ ▼
CYBB
CYP11A1
CYP11B1
CYP11B2 ◆ ■ ▼
CYP17A1
CYP19A1
CYP1B1
CYP21A2 ◆ ● ■
CYP27A1 ◆ ■ ▼
CYP27B1
DBT
DCAF17
DCLRE1C
DDR2
DGUOK
DHCR24
DHCR7 ◗ ▲ ◆ ● ■ ✠ ▼
DHDDS ◆ ● ▼
DKC1
DLD ◆ ● ✠ ▼
DLL3
DMD ▲ ◆ ● ■ ✠ ▼
DNAH5 ◆ ● ▼
DNAI1 ◆ ● ▼
DNAI2 ◆ ● ▼
DOK7
DOLK
DPYD ✚
DUOX2
DUOXA2
DYSF ◆ ■ ▼
EDA
EIF2AK3
EIF2B5
EMD
EOGT
EPB42
ERBB3
ERCC5
ERCC6
ERCC8
ESCO2
ETFA
ETFB
ETFDH ▼
ETHE1
EVC ▼
EVC2
EXOSC3
EYS ◆ ■ ▼
F2 ✚
F5 ✚
F11 ◆ ● ▼
F7
F9
FAH ◆ ● ✠ ▼
FAM161A ◆ ● ■ ▼
FANCA ◆ ■ ▼
FANCC ◆ ● ✠ ▼
FANCG ▼
FBP1
FH ▼
FKBP10
FKRP
FKTN ◆ ● ✠ ▼
FMR1 ◗ ▲ ◆ ● ■ ✠ ▼
CGG Repeat Analysis and Full Gene Sequencing, Reflex AGG Repeat Analysis for Patients with 55-90 CGG Repeats
FOLR1
FOXRED1
FRMD4A
FUCA1
G6PC ◆ ● ✠ ▼
G6PC3
G6PD ✚
GAA ◆ ● ■ ▼
GALC ▼
GALE
GALK1 ▼
GALNS
GALNT3
GALT ◆ ● ✠ ▼
GAMT
GATM
GBA ◆ ● ✠ ▼
GBE1 ◆ ● ▼
GCDH ▼
GDF5 ✚
GFM1
GHR
GHRHR
GJB1
GJB2 ◆ ● ▼
GLA
GLB1 ▼
GLDC
GLE1 ▼
GNE ◆ ■ ▼
GNPTAB ▼
GNPTG
GNS
GORAB
GP1BA
GP9
GPR56
GRHPR
GSS
GUCY2D
GUSB
GYS2
HADH
HADHA
HADHB
HAX1
HBA1/HBA2 ▲ ◆ ● ■ ✠ ▼
HBB ▲ ◆ ● ■ ✠ ▼
HEXA ◆ ● ■ ▼
HEXB ▼
HFE ✚
HFE2
HGD
HGSNAT
HLCS ▼
HMGCL
HMGCS2
HOGA1 ◆ ● ▼
HPD
HPS1 ▼
HPS3 ◆ ● ▼
HPS4
HPS6
HSD17B3 ✚
HSD17B4
HSD3B2
HSD3B7
HYAL1
HYLS1 ▼
IDS
IDUA ✠
IGHMBP2
IGSF1
IKBKAP ◆ ● ✠ ▼
IL2RG
IL7R
INVS
ITGA2B
ITGA6
ITGB3
ITGB4
IVD ✠
IYD
JAK3
KCNJ11 ▼
L1CAM
LAMA2
LAMA3
LAMB3
LAMC2
LCA5
LDLR ◆ ● ▼
LDLRAP1
LHCGR ✚
LHX3
LIFR
LIPA ◆ ■ ▼
LMAN1
LMBRD1
LOXHD1 ◆ ● ▼
LPAR6
LPL
LRPPRC ▼
LYST
MAN2B1
MANBA
MAT1A
MCCC1
MCCC2
MCEE
MCOLN1 ◆ ● ✠ ▼
MED17 ◆ ■ ▼
MEFV ◆ ● ■ ▼
MESP2
MFSD8
MKS1 ▼
MLC1 ◆ ■ ▼
MLYCD
MMAA
MMAB
MMACHC ✠
MMADHC
MOCS1
MPI
MPL ◆ ● ▼
MPV17
MRE11
MTHFR **NOW INCLUDING Sequencing except variant below** ◆ ■ ▼
c.665C>T (p.Ala222Val) variant only ✚
MTM1
MTR
MTRR
MTTP ◆ ● ▼
MUT
MYO15A
MYO7A ▼
NAGLU
NAGS
NBEAL2
NBN
NDRG1
NDUFA11
NDUFAF2
NDUFAF5 ◆ ▼
NDUFS4
vNDUFS6 ◆ ■ ▼
NDUFS7
NDUFV1
NEB ◆ ● ✠ ▼
NEU1
NGLY1
NPC1
NPC2
NPHP1
NPHS1 ▼
NPHS2
NR0B1
NR2E3 ◆ ● ▼
NTRK1 ◆ ■ ▼
OAT ◆ ■ ▼
OCRL
OPA3 ◆ ■ ▼
OTC
OTOF
PAH ◆ ● ■ ✠ ▼
PC ▲
PCBD1
PCCA
PCCB
PCDH15 ◆ ● ✠ ▼
PDHA1
PDHB
PEPD
PET100
PEX1 ✠
PEX10
PEX12
PEX2 ◆ ● ▼
PEX26
PEX6 ◆ ■ ▼
PEX7 ✠
PFKM ◆ ● ▼
PHGDH ◆ ● ▼
PHKB
PIGN
PIP5K1C
PJVK
PKHD1 ◆ ● ✠ ▼
PLA2G6
PLAA
PLOD1
PMM2 ▲ ◆ ● ■ ✠ ▼
PNPO
POC1A
POLG
POLH
POMGNT1 ▼
POR
POU1F1
PPT1 ▼
PRCD
PRICKLE1
PROP1 ▼
PRPS1
PSAP
PTPRC
PTS
PUS1 ◆ ■ ▼
PYGL
PYGM ◆ ■ ▼
QDPR
RAB23
RAG1
RAG2 ◆ ■ ▼
RAPSN ◆ ■ ▼
RARS2 ◆ ■ ▼
RDH12
RDH5
RHAG
RLBP1 ✚
RMRP ▼
RNASEH2C
ROGDI
RPE65 ◆ ■ ▼
RPGRIP1L
RS1
RSPH9
RTEL1 ◆ ● ▼
RYR1 ✚
SACS ▼
SAMHD1
SARS2
SBDS
SCO1
SEC23B
SEPSECS ◆ ■ ▼
SERPINA1 ✚
SGCA
SGCB
SGCD
SGCG
SGSH
SLC12A3 ▼
SLC12A6 ▼
SLC17A5 ▼
SLC19A2
SLC1A4
SLC22A5 ▼
SLC25A13 ▼
SLC25A15
SLC25A20
SLC26A2 ▼
SLC26A3
SLC26A4 ▼
SLC2A2
SLC34A3
SLC35A3 ◆ ● ▼
SLC37A4
SLC39A4
SLC3A1
SLC45A2
SLC4A1
SLC4A11
SLC5A5
SLC6A8
SLC7A7
SMARCAL1
SMN1/SMN2 **NOW INCLUDING sequencing of Exons 2a-7 in SMN1** ◗ ▲ ◆ ● ■ ✠ ▼
SMPD1 ◆ ● ✠ ▼
SNAP29
SNX10
SPR
SRD5A2 ✚
ST3GAL5
STAR
SUCLA2
SUMF1 ◆ ● ▼
SURF1
SYNE4
TAT
TAZ
TBCE
TBX19
TCIRG1 ◆ ● ▼
TECPR2 ◆ ■ ▼
TFR2
TG
TGM1 ▼
TH
TK2
TMC1
TMEM216 ◆ ● ✠ ▼
TMPRSS3
TPO
TPP1 ▼
TREX1
TRHR
TRIM32
TRIM37
TRMU ◆ ■ ▼
TRPM6
TSEN54
TSFM ▼
TSHB
TSHR
TTC37
TTPA
TULP1
TYMP ◆ ■ ▼
TYR
TYRP1
UGT1A1 ✚
USH1C ▼
USH2A ◆ ■ ▼
VDR
VPS11
VPS13A ◆ ● ▼
VPS13B
VPS45
VPS53
VRK1 ◆ ● ▼
VSX2 ◆ ■ ▼
VWF ✚
WAS
WISP3
WNT10A
WRN
XPA
XPC
ZFYVE26

KEY FOR SMALLER PANELS

◗ S4 – Standard Pan-ethnic Panel
▲ HF – High Frequency Pan-ethnic Panel
◆ CJ – Comprehensive Jewish Carrier Screen
● AJ – Ashkenazi Jewish Disorders
■ SJ – Sephardi-Mizrahi Jewish Disorders
✠ 39 – ECS 39
▼ 152 – ECS 152
✚ Case by case/opt-in only
Bolded Genes – New to the ECS 502 panel
Underlined Genes – Supplemental X-linked panel

v06/21/21

COMPLETE AND SUBMIT ALL PAGES TO LABORATORY

Informed Consent for Genetic Testing

If you are under eighteen (18) years of age, a legal representative who is at least eighteen (18) years of age and has the legal authority and capacity to do so must sign this consent and authorization on your behalf.

I hereby request genetic testing, which may include molecular, cytogenetic, and/or biochemical analyses, for myself. I have received verbal and written information (please see 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 the 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 or in other genes that are not included in the test. 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.

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 (GINA) may prohibit discrimination based on genetic information by employers and health insurances. 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.

Sample storage for future clinical purposes

I authorize and consent to Sema4 storing a portion of my sample indefinitely for the sole purpose of performing future clinical testing, provided it meets Sema4's storage criteria. My sample will not be used for any other purpose without my consent, and no test will be performed on my sample other than the one(s) authorized by me and my healthcare provider. The consent preferences that I set now apply to all tests that I have undergone with Sema4 to date. I understand that I can withdraw this consent by emailing privacy@sema4.com, and my sample will be destroyed at the end of the testing process or not more than 60 days after collection, whichever occurs later.

De-identified research

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 emailing privacy@sema4.com, 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.

Permission to contact

I understand that Sema4 may wish to contact me in the future, including for the following reasons: research purposes, the provision of general information about research findings, and/or the provision of information about the results of tests on my sample(s). I understand that I may notify Sema4 to opt out of such future contact by emailing privacy@sema4.com.

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.

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

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