Laboratory of Personalized Genomic Medicine

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Columbia University

College of Physicians

and Surgeons

Precision Genomics Laboratory

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Maternal Fetal Medicine Rec	uisition Informed Consent MUST be signed by Patient. Parent/Legal Guardian or Legal Next of Kin.
	Clock Constant Const

0	DATE COLLECTED (MM/DD/YY)	TIME COLL	ECTED		CLINICIAN NAME	EMAIL		
INF	DATE SENT	FROZEN						
MPLE				NOL	INSTITUTION	TELEPHONE NUMBER		
SA	COPPECTED RA			IMAT	ADDRESS	CITY/STATE/ ZIP		
	LAST NAME FIRST NAME M.I.		INFOI	SIGNATURE	DATE			
N				IAN]	NOTE TO HEALTH CARE PRACTITION	NER: It is New York State Law and Columbia		
IATIO	DATE OF BIRTH (MM/DD/YY)	MRN	sex	HYSIC	University Policy that an informed cons predisposition testing and maintained	sent is obtained prior to performing genetic		
FORM	ADDRESS			NG PI	appropriate disease/gene information/	/informed consent sheet, ensure that the		
IT IN					patient consents to having the sample i	retained in the lab for greater than 60 days, please		
ATIEN	CITY/STATE/ZIP			OR	include a copy of the consent form with informed consent to perform genetic	n this requisition. I have obtained a signed c testing in accordance with New York State		
P	HOME PHONE	WORK PH	DNE	_	Civil Rights Law, 79-L, and the inform	ned consent is retained in the patient's medical		
	ETHNICITY 🗆 ASIAN 🛛 AFRICAN - AMERICAN 🗆 CAUCASIAN				NAME OF INSURED	DATE OF BIRTH		
				_	RELATIONSHIP TO PATIENT: LI SELF L NAME OF INSURANCE COMPANY:	PARENT SPOUSE CHILD CHILD		
N	Family History of Genetic Condition? YES NO (1st, 2nd, or 3rd degree relative) SPECIFY CONDITION			NC	Address			
IATI0	Is patient pregnant? Is patient on oral contraception?			MATI	Descuell	- 6 1		
FORM	YES NO		Li NU	VFOR	POLICY #:	GROUP #:		
AL IN	LBS	LBS			PREAUTHORIZATION: If health insurance preauthorization is required, check here if preauthorization is pending:			
TINIC	GESTATIONAL AGE	CALCULATED ON DATE (MM/DD/YY)	DATING METHOD	ISUR/	INSTITUTIONAL BILLING (CLINICIAN): Do y	rou have a Instituional Billing Account?		
0	WEEKS DAYS			I	(Please contact the laboratory to establ	lish an account)		
	Multiple gestation pregna	ancy? YES	NO UNKNOWN	_	CREDIT CARD (PATIENT): I have provided	my credit card information to the Pathology Billing		
	Did patient use an egg do	nor? \Box YES \Box	NO AGE OF DONOR	_	MEDICARE PATIENTS ONLY: Check here to	confirm that an Advance Beneficiary Notice (ABN) was		
	Did patient use a surroga	te? LIYES LI	NU		signed by the Patient:			
GENETIC CARRIER SCREENING								
		□ Cystic Fibrosis* ONLY □ FMR1 - Fragile X ONLY						
	Cystic Fibrosis* O	NLY			FMR1 - Fragile X ONLY			
	□ Cystic Fibrosis* 0 □ Spinal Muscular A −	NLY trophy (SMA) ON	LY		□ FMR1 - Fragile X ONLY □ EXPANDED SCREENING: Cystic Fib	prosis* + SMA + Fragile X		
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