UNITY POWERED BY Billion To One

Carrier Screen with Reflex NIPT

CFTR • SMN1 • HBB • HBA1 • HBA2

REQUISITION FORM

INSTRUCTIONS

1. Collect the patient's sample by following the instructions in the UNITY™ kit.
2. Place the barcode sticker from box on this form.
3. Complete and place this form in the box along with the sample.

SAMPLE COLLECTION DATE MM-DD-YYYY

PLACE BARCODE HERE

PATIENT INFORMATION

Shaded fields must be completed

First Name | MI | Last Name

Sex

Pregnant? ☐ Yes ☐ No

Estimated Due Date MM-DD-YYYY

Twin / Triplet / Surrogate / Egg Donor Pregnancy? ☐ Yes ☐ No

Date of Birth (MM-DD-YYYY) | Cell Phone | Email Address

Street Address | Apt / Unit / Suite

City | State | Zip Code

Ethnicity *Select all that apply*

- ☐ Asian
- ☐ African or African American
- ☐ Ashkenazi Jewish
- ☐ French Canadian or Cajun
- ☐ Hispanic
- ☐ Northern European
- ☐ Other
- ☐ Unknown

Family History *Describe relevant family history or prior testing*

CLINIC INFORMATION

Shaded fields must be completed

Clinic Name

Clinic Phone | Clinic Fax | Clinic Account Number

Clinic Address

Ordering Healthcare Provider(s) *List and select all that apply*

Genetic Counselor *If applicable*

BILLING INFORMATION

Select one option and provide necessary details

☐ **Bill to Insurance**
Includes Medicaid and Tricare

Policy Owner Name

Insurance Company Name

Member ID Number

Relationship to Insured

- ☐ Self
- ☐ Dependent
- ☐ Other

☐ **Bill to Patient**

Card Holder Name | Card Expiry Date (MM/YY)

Card Number | CVV

CLINICAL INDICATION

Select all that apply. Codes below are not exhaustive, provide additional as necessary.

☐ Screening for genetic disease carrier status	Z31.430, Z31.440, Z13.71
☐ Supervision, normal 1st pregnancy	Z34.00, Z34.01, Z34.02, Z34.03
☐ Supervision, other normal pregnancy	Z34.80, Z34.81, Z34.82, Z34.83
☐ Family history	Z84.39, Z84.81
☐ Supervision of elderly primigravida	O09.511, O09.512, O09.521, O09.522
☐ Other ICD-10 codes:	*Include patient's chart notes*

Authorization

By submitting this requisition, I confirm that I have obtained the patient's informed consent for the requested screening. I confirm that this screen is clinically valuable for the patient.

Physician Signature | Date of Authorization (MM-DD-YYYY)

OPTIONAL PATIENT ACKNOWLEDGEMENT

By signing below, I agree that my de-identified results may be shared with genetic databases in order to advance medical research. By not signing, my de-identified data will NOT be shared. BillionToOne respects your privacy and is committed to protecting it. For more information about our privacy policies please visit *www.unityscreen.com/privacy*.

Patient Signature | Date (MM-DD-YYYY)

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