PAYMENT CONFIRMATION (ORDER) # : _____

Payment must be completed online at www.mssscreening.com prior to shipping sample(s). Please follow the payment instruction form for more information.

CARRIER SCREENING REQUISITION FORM

PRIMARY PATIENT

LAST NAME	FIRST NAME	
DATE OF BIRTH (MM/DD/YYYY)	GENETIC SEX ◯ Male ◯ Female ◯ Other	
MED REC#/PATIENT IDENTIFIER	ETHNICITY	
ADDRESS		
CITY	STATE/PROVINCE	POSTAL CODE
PHONE	EMAIL	
SAMPLE DRAW DATE (MM/DD/YYYY)	SAMPLE TYPE ◯ Blood ◯ Buccal (cheek)	
SCREENING PANEL ☑ MSS Expanded Carrier Screening	NUMBER OF GENES* 410	
INDICATIONS FOR SCREENING Check all that apply. ◯ Patient Screening ◯ Partner Screening ◯ Pregnancy ◯ Family History ◯ Infertility ◯ Egg/Sperm Donor ◯ Other:	DUE DATE IF PREGNANT (MM/DD/YYYY)	
	ULTRASOUND FINDINGS/CLINICAL TESTING	

*Males will not be screened for x-linked conditions.

☑ Opt out of research

Genetic material and the raw data will be used for the patient's clinical purposes and will not be stored, used or sold for research.

I have read the informed consent document and I give permission to Fulgent Genetics to perform genetic screening as described.

PATIENT SIGNATURE (REQUIRED) X	DATE (MM/DD/YYYY)

ORDER PROVIDER

INSTITUTION/PRACTICE NAME	INSTITUTION PHONE/FAX/EMAIL	
PROVIDER LAST NAME	PROVIDER FIRST NAME	
MINC (CANADA)	PROVIDER TITLE (MD, DO, GC)	
PROVIDER ADDRESS		
CITY	PROVINCE	POSTAL CODE
PROVIDER PHONE	FAX REPORT TO	
GC/PRIMARY CONTACT	PRIMARY CONTACT PHONE/EMAIL/FAX	
CLINICAL / FAMILY HISTORY (OPTIONAL)		

I have fully informed the patient about the nature, purpose, capabilities, and limitations of and alternatives to the ordered screen, and answered any patient questions to their satisfaction.

STATEMENT OF MEDICAL NECESSITY

By signing below, I, the ordering Medical Provider, confirm that screening is medically necessary and that screen results may impact medical management for the patient.

ORDERING PROVIDER SIGNATURE (REQUIRED) X	DATE (MM/DD/YYYY)

MERGED COUPLE REPORT This section must be completed for a merged couple report

PARTNER LAST NAME	PARTNER FIRST NAME
GENETIC SEX ◯ Male ◯ Female ◯ Other	ETHNICITY
DATE OF BIRTH (MM/DD/YYYY)	FULGENT ACCESSIONID
SAMPLE DRAW DATE (MM/DD/YYYY)	SAMPLE TYPE ◯ Blood ◯ Buccal (cheek)
I have read the informed consent document and I give permission to Fulgent Genetics to perform genetic screening as described.	
PARTNER SIGNATURE (REQUIRED) X	DATE (MM/DD/YYYY)

Please note:

- If not signed by the partner, separate reports will be issued.
- By signing, the partner will be authorizing the release of their results to the primary patient's healthcare provider, which may include sensitive medical information. The results will become part of the patient's medical record.
- Merged couples reports can only be produced for patients and partners that have ordered the same screen. If screens do not match individual reports will be produced.
- Partner's sample is not needed if they have been previously screened at Fulgent and has a Fulgent AccessionID. This can be found on the top of a report.
- Please note that if the partner's sample is not sent together and no Fulgent AccessionID is specified, individual reports will be produced. It is possible to call Fulgent and obtain the Fulgent AccessionID of recently submitted screens that have not been reported at the time of a partner requisition.

MSS is associated with Sinai Health System. Net proceeds from the program will be reinvested to support patient care and research at Sinai Health. Sinai Health has been involved in the validation of the medical content of the document and other program support. MSS takes responsibility for its overall content.

Compensation may be provided to physicians or associated parties for test kits ordered as a result of their consultation, subject to applicable law and standards of practice.

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Mount Sinai SERVICES

CARRIER SCREENING

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