



KAISER PERMANENTE® Northern Colorado NIPT Laboratory Requisition

UPIN / NPI#:	FILL IN ALL INFORMATION PATIENT NAME (Last, First):
PROVIDER NAME:	
ADDRESS:	DATE OF BIRTH:
	Kaiser PERMANENTE HEALTH RECORD MEMBER ID #:
PHONE NUMBER:	Circle one: STAT Routine
FAX NUMBER:	
10 DIAGNOSIS CODE(s): **REQUIRED**	Date Ordered:
**Medicare does not generally cover routine screening tests	PROVIDER: Please sign and date below. Then FAX order to: 303-404-4030 or 1-877-489-5586

NIPT- TRISOMY 21, 18, 13 ANEUPLOIDY ANALYSIS W SEX CHROMOSOMES, MATERNAL BLOOD, DIRECTED CFDNA ANALYSIS.

[Answer all Questions]

Number of fetuses? _____ 3 or more (DO NOT ORDER THIS TEST)

EDD by sono only: Date? _____

Age of patient/donor at egg retrieval (yrs.): Numeric: _____

Maternal weight (lbs.): _____

[Circle appropriate answers]

IVF pregnancy? Yes/No

Egg used in IVF: Donor/Patient

Reason for testing?

- Advanced Maternal Age
- Abnormal Prenatal Screen
- Abnormal Ultrasound
- Family History of Chromosome Abnormalities
- Other

Patient/Family Hx of Aneuploidy? Yes/No

If Yes, Specify condition and relation: _____

No appointments necessary for routine laboratory testing at any Kaiser Permanente lab facility.
Laboratory hours: 9 a.m. to 5 p.m., weekdays.
PLEASE NOTE: Specimens from outside of Kaiser Permanente will not be accepted.
**TESTING ORDERED MUST BE MEDICALLY NECESSARY TO PREVENT, DIAGNOSE, OR TREAT A MEDICAL CONDITION. THE TESTS ON THIS ORDER FORM HAVE BEEN APPROVED BY THE ATTENDING PHYSICIAN. (PLEASE SIGN/DATE BELOW)
_____ Signature
Date: _____