Mount Sinai Services
Sinai Health

fulgent

TEST REQUISITION FORM

KNOVA Prenatal Screen (NIPT/NIPS)

Patient information

Last name* | First name*

Sex assigned at birth | Date of birth (mm/dd/yyyy)* | Ethnicity

Address

City | Province | Postal code | Country

Phone* | Email*

Blood draw collection date* (mm/dd/yyyy) | MRN

Ordering provider

Client name/id (For lab use)

Institution/practice name

Institution phone / fax*

Institution email

Ordering provider(s)*

Additional fax or email for report delivery

Name _____

Fax _____

Email _____

Patient acknowledgement

I confirm that I have been informed about the details of the Fulgent prenatal NIPT/NIPS test, including the purpose, capabilities, and limitations of the ordered tests. I have read the Informed Consent document provided by Mount Sinai Services and I give permission to Fulgent Genetics and its entities to perform genetic testing as described. More information is available at www.fulgentgenetics.com/policies/privacy-policy

Confirmation number (Mandatory for blood draw)

X _____ Patient signature (Required)

_____ Date (mm/dd/yyyy)

Statement of informed consent

By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient. I attest that the patient has been fully informed about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

X _____ Ordering provider signature (Required)

_____ Date (mm/dd/yyyy)

Clinical information

Gestational age*: _____weeks _____days

Patient must be at least 10 weeks 0 days gestational age for testing.

Maternal Weight: _____lbs.

Maternal Height: _____ft. _____in.

Pregnancy Type* (Pregnancies with 3 or more fetuses are not eligible for testing)

○ Singleton ○

KNOVA cannot be performed for twin pregnancies, cases where there has been an IVF pregnancy using a donor egg, a fetal demise, vanishing twin, or reduction.

IVF pregnancy?

○ Yes ○ No

If yes, egg contributor is ○ Patient ○ Other individual

Egg contributor age at retrieval: _____ years

Clinical History

☐ Pregnancy reduction in current pregnancy
☐ Vanishing twin in current pregnancy

☐ History of malignancy
☐ Uterine fibroids
☐ Bone marrow transplant/ blood transfusion

☐ Family history of genetic condition
☐ Known familial variant (specify gene and variant):

_____

☐ Ultrasound abnormality (specify):

_____

☐ Abnormal maternal serum screen

Order online - payment required before blood draw

https://mount-sinai-services.myshopify.com/collections/coming-soon/products/knova-nipt

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Test options

Select*:

- ◉ **Full KNOVA Panel** (singleton pregnancies only; testing cannot be performed in cases with a history of egg donor, fetal demise, vanishing twin, or reduction): Prenatal Cell-free DNA screening for all aneuploidies, microdeletions, and monogenic conditions.

Specimen requirements



Two 10 mL Streck Cell-Free DNA BCT

Contact **clientservices@fulgentgenetics.com** for KNOVA NIPT/NIPS Specimen Kits

Clinical indications

Select all appropriate:

Supervision of elderly primigravida	☐ O09.511	☐ O09.512	☐ O09.513
Supervision of elderly multigravida	☐ O09.521	☐ O09.522	☐ O09.523
Supervision of other high risk pregnancies	☐ O09.891	☐ O09.892	
Abnormal/Positive serum screening	☐ O28.0	☐ O28.1	
Abnormal findings	☐ O28.3	☐ O28.5	☐ O28.9

Encounter for supervision of normal first pregnancy	☐ Z34.00	☐ Z34.01	☐ Z34.02
Supervision of other normal pregnancy	☐ Z34.80	☐ Z34.81	☐ Z34.82
Family History	☐ Z84.81	☐ Z84.89	
Personal History	☐ Z86.000	☐ Z86.001	☐ Z86.002

Maternal care for other (suspected) hereditary disease in fetal, not applicable/unspecified ☐ O35.2XX0

Ultrasound abnormality or other ICD-10 code: _____

Describe or attach family history:

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