Appendix K

California Department of PublicHealth

Consent & cfDNA Order Confirmation

California Prenatal Screening Program

For lab use only
Do not cover

Patient

Last Name:	Dominguez
First Name:	Jane
Medical Record #:	165253
Date of Birth:	10/12/1995
Patient Phone #:	(415) 334-3267
IVF/Ovum Donor Used?:	Yes
Number of Fetuses:	2

Order

PNS Form #:	D 22 AH234 77
Analysis Lab:	cfDNA company
Estimated Due Date:	08/12/2022
Clinician Last:	Johanssen
Clinician First:	Nicholas
Clinician Phone #:	(916) 354-3456

Patient Consent

If you give consent to prenatal screening by signing below, your blood will be collected and sent to a state-contracted laboratory for prenatal screening.

- *I consent to participate in the California Prenatal Screening Program.*
- *I authorize the release of medical and any other information about myself that is needed for my health insurance claim.*
- *I authorize payment of medical benefits to the Genetic Disease Screening Program (GDSP) for the services provided to me.*
- *I consent to be billed directly for the services provided to me if I do not have health insurance coverage or Medi-Cal.*
- *I informed my provider whether to disclose fetal sex through the California Prenatal Screening Program.*

Patient/Authorized Person Signature: _____ **Date:** M M / D D / Y Y Y Y

☐ Attestation that verbal consent from patient was obtained:

Provider/Representative Name

Relationship to Patient

Based on Gestational Age, the recommended patient blood draw date range: **02/22/2022 – 05/23/2022**

Blood Draw Facility

Blood Draw Facility Name

Blood Draw Facility Phone # - -

Blood Draw Date M M / D D / Y Y Y Y

Collector's Initials

Copy of insurance card ↓ | Blood draw tube ↓ | Extra label ✓ | Do not remove ×

Dominguez, S
D 22 AH234 77
Collected on: __/__/_____

Dominguez, S
D 22 AH234 77
Collected on: __/__/_____

Dominguez, S
D 22 AH234 77
Collected on: __/__/_____

Dominguez, S
D 22 AH234 77
Collected on: __/__/_____