PreTRM®
Test for Risk Management

Test Request Form

LabCorp account number: **43702170**
Test number: **830395**

REQUIRED FOR ORDERING HEALTHCARE PROVIDER
REQUIRED FOR SPECIMEN COLLECTION/PHLEBOTOMY

FOR SPECIMEN COLLECTION USE ONLY

SPECIMEN LABEL HERE

Patient Information

Last Name	First Name	M.I.	Patient Sex ◯ F ◯ M
Birth Date / MRN or Patient ID	Email *(used to contact patient for support or billing)*		
Address	City		
State / Zip	Cell or Primary Phone *(used to contact patient for support or billing)*		

Billing Information

Billing Options
◯ **Bill Insurance** *(please attach copy of insurance card and fill insurance information below)* ◯ **Self Pay** *(patient will be contacted regarding payment; do not complete billing information below)*

Primary Insured	Subscriber Name (Primary)	Subscriber Address (Primary)
Patient relationship to policyholder ◯ Self ◯ Spouse ◯ Child ◯ Other:_____	Date of Birth / Group Number (Primary)	Policy Number (Primary)
Secondary Insured	Subscriber Name (Secondary)	Subscriber Address (Secondary)
Patient relationship to policyholder ◯ Self ◯ Spouse ◯ Child ◯ Other:_____	Date of Birth / Group Number (Secondary)	Policy Number (Secondary)

Patient Clinical Information & Intended Use

Intended Use (**YES** or **NO** must be selected for each criteria)

YES	NO	
◯	◯	Asymptomatic for preterm labor
◯	◯	Singleton Pregnancy
◯	◯	18 years of age or older
◯	◯	Progesterone therapy after first trimester
◯	◯	Previous history of preterm birth
◯	◯	Heparin therapy
◯	◯	Confirmed fetal genetic abnormality and/or structural anomaly associated with shortened gestation

Due Date (mm/dd/yyyy) _____ /_____ /_____

Height (ft. in.)

Pre-pregnancy Weight (lbs.)

Common ICD10 Code(s):

- ☐ **Z34.00** ENC SUPV NORMAL FIRST PREG UNS TRI
- ☐ **Z43.01** ENC SUPV NORMAL FIRST PREG 2 TRI
- ☐ **Z34.02** ENC SUPV OTH NORMAL PREG FIRST TRI
- ☐ **Z34.80** ENC SUPV NORMAL PREG UNS UNS TRI
- ☐ **Z34.81** ENC SUPV NORMAL FIRST PREG 1 TRI
- ☐ **Z34.82** ENC SUPV OTHER NORMAL PREG UNS TRI
- ☐ **Z34.90** ENC SUPV OTH NORMAL PREG SECOND TRI
- ☐ **Z34.91** ENC SUP NORMAL PREG UNS FIRST TRI

☐ **Other ICD10 Code(s)** _____

Test Requested

☑ The **PreTRM® Test** for Risk Management predicts the risk of spontaneous preterm birth (before 37 weeks) in asymptomatic women (no signs or symptoms of preterm labor with intact membranes) ≥18 years old with a singleton pregnancy. The PreTRM Test is performed via a single blood draw between 19wk/1d – 20wk/6d (134 – 146 days) gestation. It is not intended for use in women who have a multiple pregnancy, have a known or suspected fetal anomaly, or are on any form of progesterone therapy after the first trimester.

Ordering Healthcare Provider Attestation

Ordering Healthcare Provider	NPI
Healthcare Organization Name	Primary Office Contact
Contact Phone / Secure Fax	Primary Contact Email
Address	State / ZIP

Ordering Healthcare Provider Attestation

I am a licensed healthcare provider authorized to order PreTRM. I have determined that this test is medically necessary for this patient. The patient has consented and is eligible to use PreTRM. I acknowledge it may be necessary for Sera Prognostics to directly contact the patient for the purposes of obtaining reimbursement for the test and/or to collect additional samples as appropriate.

_____ _____
Ordering Healthcare Provider Signature | Date

Patient Blood Draw Information

Patient blood draw for the PreTRM Test must occur within the window (from gestational age 19wk/1d - 20wk/6d)

Blood Draw Window:

FROM _____ /_____ /_____ **TO** _____ /_____ /_____

Blood samples drawn before or after the window will not be tested.

Fasting is not required.

PHLEBOTOMY INFORMATION (UNLESS CAPTURED BY OTHER ELECTRONIC MEANS)

Draw Site Name	Draw Date / Time
	_____ /_____ /_____ _____:_____ ☐ AM ☐ PM

SERA PROGNOSTICS™
The Pregnancy Company™

Customer Support: Phone (801) 990-6600 / Fax (801) 990-6601 / support@pretrm.com

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Print Copy For Patient