# PreTRM® | TEST REQUEST FORM

PRINT COPY FOR PATIENT

## PATIENT INFORMATION

| LAST NAME | FIRST NAME | MI | DOB / / | MRN/ PATIENT ID | GENDER |
|---|---|---|---|---|---|
| | | | | | |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| PHONE | EMAIL | LANGUAGE PREFERENCE |
|---|---|---|
| | | ◯ English ◯ _____ |

## INTENDED USE

☑ 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 sample between $18^{0/7}$ – $20^{6/7}$ weeks gestation (126 – 146 days). It is not intended for use in women who have a multiple pregnancy or have a known or suspected fetal anomaly.

## PATIENT CLINICAL INFORMATION

| DUE DATE / / | HEIGHT (FT/IN) | PRE-PREGNANCY WEIGHT (LBS) |
|---|---|---|
| | | |

**Please Complete All Required Fields Prior to Testing for Optimal Results:**

| YES | NO | |
|---|---|---|
| ◯ | ◯ | Prior live birth |
| ◯ | ◯ | Prior preterm birth (<37 weeks) |
| ◯ | ◯ | Pre-gestational (type 1 or 2) diabetes |
| ◯ | ◯ | Chronic hypertension prior to pregnancy |
| ◯ | ◯ | Prior preeclampsia |

## DIAGNOSIS CODES

**Select Applicable ICD-10 Diagnosis Code(s):**

◯ **Z34.82** ENC SUPV OTH NORMAL PREG SECOND TRI

◯ **Z34.92** ENC SUP NORMAL PREG UNS SECOND TRI

◯ **Z34.02** ENC SUPV NORMAL FIRST PREG 2 TRI

◯ _____

## HEALTHCARE PROVIDER INFORMATION

| ORDERING PROVIDER | ORGANIZATION | NPI |
|---|---|---|
| | | |

| CONTACT | PHONE | EMAIL | FAX |
|---|---|---|---|
| | | | |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

## BILLING INFORMATION

◯ **Bill Insurance** *Please attach copy of insurance card and fill out the information below*

◯ **Self Pay** *Patient will be contacted regarding payment; do not complete billing information below*

◯ **Client Bill** *Sera Prognostics will invoice your practice/location directly, and your patient will not receive a bill from Sera Prognostics*

**Primary**

| INSURANCE | POLICY HOLDER NAME | POLICY HOLDER ADDRESS |
|---|---|---|
| | | |

| PATIENT RELATIONSHIP TO POLICY HOLDER | DATE OF BIRTH | GROUP NUMBER | POLICY NUMBER |
|---|---|---|---|
| | | | |

**Secondary**

| INSURANCE | POLICY HOLDER NAME | POLICY HOLDER ADDRESS |
|---|---|---|
| | | |

| PATIENT RELATIONSHIP TO POLICY HOLDER | DATE OF BIRTH | GROUP NUMBER | POLICY NUMBER |
|---|---|---|---|
| | | | |

## BLOOD SAMPLE INFORMATION

SAMPLE COLLECTION DATE / /

Patient blood sample for the PreTRM Test must occur from **gestational age 18 weeks — 20 weeks/6 days.** Blood samples taken before or after the window will not be tested. Fasting is not required.

PreTRM®
Test for Risk Management

**CALL:** (801) 990-6600 **FAX:** (801) 990-6601 **EMAIL:** support@pretrm.com

## ORDERING HEALTHCARE PROVIDER ATTESTATION & PATIENT CONSENT

Health Care Provider Signature

Date / /

I am a licensed healthcare provider authorized to order PreTRM. I have determined that this test is medically necessary for this patient. I am aware of the limitations and intended use of the PreTRM test. 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.

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