Genetic Counseling Patient Acknowledgement

Your healthcare provider has referred you to Natera for genetic counseling. Genetic counseling is the process of helping people understand and adapt to the medical, psychological, and familial implications of genetic contributions to disease. Natera is a diagnostics company that offers testing in addition to genetic counseling services. The genetic counselor who will conduct your genetic counseling session is employed by Natera.

Your genetic counseling appointment will occur over video. I understand that Natera's policy is not to allow any recording (audio or video) of genetic counseling sessions. During the session, the genetic counselor will ask you questions about your personal medical history and your family medical history. If you are pregnant, the genetic counselor will also ask for the personal medical history and family medical history of your partner or other biological parent(s) of the pregnancy. Based on this information, the genetic counselor will discuss the possible risk(s) for identified genetic/medical conditions that may affect you and/or your offspring.

It is your responsibility to provide accurate and complete information to the genetic counselor. The risks provided by the genetic counselor are dependent on the accuracy of the information you provide. In some cases, the genetic counselor may request that you obtain genetic test results or medical records from another healthcare provider or from a family member. It is your responsibility to send any requested records to the genetic counselor.

The genetic counselor will explain the tests available to you. This explanation will include the benefits, limitations and risks associated with the tests. Testing is optional. It is your choice whether or not you have any of the tests discussed.

If you decide to have any of the tests discussed during your genetic counseling session, it is your responsibility to follow-up with your healthcare provider who will order the test(s). Your healthcare provider is responsible for selecting the laboratory that will run the test(s). Most test results are available within 2-3 weeks. If you have not been contacted with your results after 3 weeks, you should follow up with your healthcare provider.

Natera's Notice of Privacy Practices (NPP) describes how Natera may use and disclose your protected health information and that Natera reserves the right to change such practices. You may also access the NPP online at www.natera.com/natera-notice-of-privacy-practices.

Charges for your genetic counseling session are separate from the charges from your healthcare provider. Natera will bill your insurance company if you have provided insurance information. You will be responsible for payment of any remaining balance, deductible, co-payment and/or co-insurance.

Reproductive Genetic Counseling Questionnaire

Patient Information

Last Name _____ First Name _____

Date of Birth _____ Age _____ Occupation _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ Email _____

Partner Information

Last Name _____ First Name _____

Date of Birth _____ Age _____ Occupation _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ Email _____

Referring Healthcare Provider

Healthcare Provider Name (Primary OB/GYN) _____

Clinic Name _____

Street Address _____

City _____ State _____ Phone _____

Pregnancy Information

Are you currently pregnant? ☐ Yes ☐ No ☐ Unsure When is your due date? _____

Is your partner the biological parent of this pregnancy? ☐ Yes ☐ No ☐ Unsure

Did you use a sperm and/or egg donor to achieve this pregnancy? ☐ Yes ☐ No ☐ Unsure

Is this your first pregnancy? ☐ Yes ☐ No ☐ Unsure

If no, please fill out the table below:

Pregnancy History

Delivery Date	Full Term or Preterm	Weeks Gestation	Biological Sex (M/F)	Outcome (Healthy, complications, etc)

Testing Information

Have you or your reproductive partner had carrier screening? ☐ Yes ☐ No ☐ Unsure

Have you or your reproductive partner had blood chromosome testing? ☐ Yes ☐ No ☐ Unsure

Have you or your reproductive partner had any other type of genetic testing? ☐ Yes ☐ No ☐ Unsure

If yes, please explain:

If pregnant, have you had any testing performed during the pregnancy? ☐ Yes ☐ No ☐ Unsure

If yes, please mark all that apply:

- ☐ Ultrasound
- ☐ Blood/serum screening for Down syndrome and/or neural tube defects and/or non-invasive prenatal screening for chromosome abnormalities
- ☐ Chorionic villus sampling (CVS)
- ☐ Amniocentesis
- ☐ Other (pls. explain)

Medications/Exposures

If pregnant, have you used or been exposed to any of the following:

- ☐ Cigarettes
- ☐ Alcohol
- ☐ Recreational drugs
- ☐ X rays (other than dental)
- ☐ Medications other than prenatal vitamins and OTC pain relievers
- ☐ Other (pls. explain)

Do you take any medications on a regular basis? ☐ Yes ☐ No ☐ Unsure

If yes, please list any medications you have taken since conception (other than prenatal vitamins and Tylenol) in table below.

Medication	Medical Condition	Dose	Dates Taken

Family Background

What countries did your and your partner's ancestors come from or to what racial/ethnic groups do you and your partner identify?

Patient _____ Partner _____

Are you and your partner related by blood? ☐ Yes ☐ No ☐ Unsure

Are you or your partner adopted? ☐ Yes ☐ No ☐ Unsure

Do you or your partner have a personal or family history of any of the following conditions? Please mark all that apply.

- ☐ Down syndrome or other chromosomal problem
- ☐ Intellectual disability, developmental delay or autism
- ☐ Cystic fibrosis
- ☐ Spinal muscular atrophy, muscular dystrophy or other neuromuscular disease
- ☐ Sickle cell disease or trait
- ☐ Hemophilia or other blood clotting disorder
- ☐ Skeletal disorder
- ☐ Epilepsy, seizures
- ☐ Neural tube defect such as spina bifida (open spine)
- ☐ Heart defect at birth
- ☐ Blindness or deafness
- ☐ Two or more pregnancy losses, stillbirth or infant death
- ☐ Infertility

☐ Birth defect not listed above (please explain)

☐ Genetic condition not listed above (please explain)

☐ Serious medical condition not listed above (please explain)

Patient Acknowledgement

I have read (or had someone read to me) the Genetic Counseling Patient Acknowledgement. The information provided in this form is correct and accurate to the best of my knowledge. Natera may use the information included herein to contact me for clinical follow-up, results, billing/collection matters and health-related products, services or studies.

☐ I can opt-out of non-clinical contact by checking this box.

☐ By checking this box, I give Natera permission to discuss my health information with my partner (listed herein).

Patient signature _____ Date _____