Constitutional Cytogenetics Requisition (non-cancer)

ACCOUNT INFORMATION

Account name: _____

Address: _____ **City:** _____ **State:** _____

Zip code: _____ **Ph:** _____ **Fax:** _____

Cytogenetics Laboratory
2330 Inwood Road, Suite EB3.304
Dallas, Texas 75235
LAB PHONE: 214-648-0930
LAB FAX: 214-648-0940
CUSTOMER SERVICE: 214-633-5227
CLIA #: 45D-0861764
CAP #: 2664213

UT Southwestern Medical Center
CLINICAL LABORATORY SERVICES

REQUIRED ORDER INFORMATION

BILL TO: ☐ Facility / Client
☐ Patient / 3rd party **– Billing information must be provided**

Patient Name: (Last, First, Middle)

Mother's Name: (if infant)

Date of Birth:	Sex:	Patient ID / MR#:

Hospital Inpatient Y / N	Collection Date:	Collection Time: AM / PM
		:

Ordering Physician (Full Name):	NPI:

Phone:	Pager:	FAX:

Clinical Indication for Tests Ordered:

SPECIMEN INFORMATION

☐Blood
☐Amniotic fluid
☐CVS
☐PUBS
☐Products of conception
☐Tissue: site/type _____
☐ Other: _____

PREGNANT PATIENTS:
LMP _____
Gest age by ultrasound:
____wks ____days

PATIENT/3RD PARTY BILLING INFORMATION

ICD-10 Code(s)

Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) available at www.veripathlabs.com or by calling customer service at 214-645-7057 or toll free 877-887-8136

☐ Signed ABN included

ICD-10 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.

Insured/Responsible Party Name: (if different from patient-Last, First, Middle)	Date of Birth:

Patient's relationship: ☐ Self ☐ Spouse ☐ Dependent ☐ Other	Responsible Party Address: (street, city, State, zip)
Sex:	Phone:

Employer's Name:	Employer's Phone:
Insurance Co. Name:	Insurance Co. Phone:
Insurance Co. Address:	
Policy #:	Group #:
☐ Medicare ☐ HMO ☐ Other ☐ Medicaid ☐ PPO	Member ID#:
Referral Authorization/Precertification #:	
Name:	Date/Time:

DIAGNOSTIC INFORMATION

PRENATAL:
☐Advanced maternal age
☐Serum screen positive for:
___ Down syndrome
___ NTD (increased MSAFP)
___ Trisomy 18
___ Other: _____
☐Abnormal fetal sonogram
_____
☐Other: _____

POSTNATAL - suspected diagnosis:
☐Down syndrome
☐Trisomy 13
☐Trisomy 18
☐Turner syndrome*
☐Other _____

*Mosaicism screen (additional cell counts) will be performed at an additional charge when routine study is normal for suspected Turner syndrome.

Check at least one symptom:
☐Ambiguous genitalia
☐Congenital anomalies
_____
_____
☐Developmental delay
☐Fetal demise/miscarriage
☐Infertility
☐Multiple miscarriages
☐Short stature
☐Family history of chromosomal anomaly
_____
☐Family history of congenital anomaly
_____
☐Other: _____

TEST REQUESTED

☐Chromosomal analysis
☐Cytogenomic microarray analysis
☐FISH **(SPECIFY FISH)** (provide prior chromosome results)
☐Amniotic fluid AFP
(AChE will be performed at an additional charge when AFAFP is positive.)
☐Amniotic fluid acetyl cholinesterase (AChE)
☐Fibroblast culture - specify test to be performed and the referral lab:
_____
_____

FISH TESTS

Aneuploidy: ☐13 ☐18 ☐21 ☐X/Y
☐Aneuploidy Panel (13, 18, 21, X/Y)

Microdeletion Syndromes:
☐Angelman
☐Cri du chat (5p-)
☐Deletion 1p36
☐DiGeorge/velo-cardio-facial (22q11.2 deletion)
☐Miller-Dieker
☐Prader-Willi
☐Smith-Magenis
☐Williams
☐Wolf-Hirschhorn (4p-)
☐Other: (call lab)
_____

REPORTING: Please specify where additional report should be sent

Name: _____ Address: _____

FAX: _____ City/State/Zip: _____

LAB USE ONLY

Transport Container: **Total # of specimens:**_____
___Yellow ___Green ___Purple ___Syringe ___Conical ___Red ___Blue ___Cup
___Trans Tube ___Block ___Slides ___Formalin ___Other: _____

Transport Conditions:
☐Frozen ☐Slushy
☐Refrig ☐Room Temp

Destination: ☐Other _____
☐Coag ☐Cytogen ☐HemePath
☐Flow ☐Hist ☐Mol Dx

Initials: