# Constitutional Cytogenetics Requisition (non-cancer)

## ACCOUNT INFORMATION

**Account name:** _____

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

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


Cytogenetics Laboratory
2330 Inwood Road, Suite EB3.302
Dallas, Texas 75235
LAB PHONE: 214-648-0975
LAB FAX: 214-648-0976
CUSTOMER SERVICE: 214-633-5227
CLIA #: 45D-0861764
CAP #: 2664213

UTSouthwestern 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. If chromosome result is normal, reflex to CMA
☐Cytogenomic microarray analysis (CMA)
☐FISH **(SPECIFY FISH)**
☐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:**