

Constitutional Cytogenetics Requisition (non-cancer)



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CLIA #45D-0659587, CAP #2723201

VERIPATH LABORATORIES

www.veripathlabs.com

ACCOUNT INFORMATION

Account name: _____
Address: _____ City: _____ State: _____
Zip code: _____ Ph: _____ Fax: _____

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: _____
PRINT NAME

Physician Signature: _____
REQUIRED FOR MEDICARE/MEDICAID PATIENTS

Phone: _____ Pager: _____ FAX: _____

Clinical Indication for Tests Ordered: _____

SPECIMEN INFORMATION

Blood **PREGNANT PATIENTS:**
 Amniotic fluid LMP _____
 CVS Gest age by ultrasound:
 PUBS _____ wks _____ days
 Products of conception
 Tissue: site/type _____
 Other: _____

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.

PATIENT/3RD PARTY BILLING INFORMATION

ICD-9 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-9 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) _____
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: _____

Check at least one symptom:
 Ambiguous genitalia Multiple miscarriages
 Congenital anomalies Short stature

 Family history of chromosomal anomaly
 Developmental delay Family history of congenital anomaly
 Fetal demise/miscarriage _____
 Infertility Other: _____

TEST REQUESTED

Chromosomal analysis
 Chromosomal analysis with FISH (SPECIFY FISH)
 FISH only (SPECIFY FISH) (provide prior chromosome results)
 Amniotic fluid AFP
(AChE will be performed at an additional charge when AFAP 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)
Telomere panel Chromosomal subtelomeric sequences
Microdeletion Syndromes:
 Angelman Prader-Willi
 Cri du chat (5p-) Smith-Magenis
 Deletion 1p36 Williams
 DiGeorge/velo-cardio-facial (22q11.2 deletion) Wolf-Hirschhorn (4p-)
 Miller-Dieker Other: (call lab) _____

REPORTING: Please specify where additional report should be sent

Name: _____ Address: _____
FAX: _____ City/State/Zip: _____

VERIPATH USE ONLY Transport Container: _____ Total # of specimens: _____ Transport Conditions: _____ Destination: Other _____ Initials: _____
 Yellow Green Purple Syringe Conical Red Blue Cup
 Trans Tube Block Slides Formalin Other: _____
 Frozen Slushy Coag Cytogen HemePath
 Refrig Room Temp Flow Hist Mol Dx