EMORY GENETICS LABORATORY

# CYTOGENETIC TEST REQUISITION FORM

2165 North Decatur Road Decatur, Georgia 30033
Phone: 855-831-7447 | 404-778-8499
Fax: 404-778-8559
http://geneticslab.emory.edu

## PATIENT INFORMATION

**Last Name** _____

**First Name** _____ **MI**____

**Parent name (if pt is a minor)/Spouse**_____

**Pt. ID/Med Rec#** _____

**DOB** _____/_____/_____ (MM/DD/YYYY)

**Gender** ☐ Male ☐ Female ☐ Unknown ☐ Ambiguous

**Ethnicity of pt. (check all that apply)**

☐ African-American ☐ Asian

☐ Caucasian/NW European ☐ E. Indian ☐ Hispanic ☐ Jewish-Ashkenazi

☐ Jewish-Sephardic ☐ Mediterranean ☐ Native American

☐ Native Hawaiian/Other Pacific Islander ☐ Other _____

**Address** _____

_____

**City** _____ **State** _____ **Zip** _____

**Preferred Phone** (_____) _____ - _____

**Secondary Phone** (_____) _____ - _____

## ENTITY ORDERING TEST (Fax # Required to Receive Report)

☐ **Physician**

**Name**_____

**NPI** _____

**Phone** (_____) _____ - _____**Fax** (_____) _____ - _____

**Email** _____

☐ **Laboratory/Institution**

**Name**_____

**Address** _____

**Address 2:** _____

**City** _____ **State** _____ **Zip** _____

**Phone** (_____) _____ - _____**Fax** (_____) _____ - _____

**Email** _____

## DUPLICATE REPORTS TO (Fax # Required to Receive Report)

☐ **Genetic Counselor**

**Name** _____

**Phone** (_____) _____ - _____**Fax** (_____) _____ - _____

**Email**_____

☐ **Other**

**Name**_____

**Phone** (_____) _____ - _____**Fax** (_____) _____ - _____

**Email** _____

## BILLING INFORMATION *Required*

**ICD9 Codes:**

**Please complete billing information on page 2 of this form.**

## SPECIMEN INFORMATION

Date Collected _____ / _____ / _____ (MM/DD/YYYY)

Time _____ : _____ ☐ AM ☐ PM

## SAMPLE TYPE

☐ Whole Blood ☐ Saliva ☐ DNA ☐ Muscle Biopsy ☐ Skin Biopsy ☐ DBS

☐ Serum ☐ Urine ☐ Plasma, Hep ☐ Plasma, EDTA ☐ Plasma, Other

☐ Leukocyte Pellet ☐ CSF ☐ Cult Fibroblast ☐ PUBS ☐ Other _____

## PRENATAL SAMPLE TYPE

☐ Amniotic Fluid ☐ Cultured Amniotic Fluid ☐ POC

☐ Chorionic Villus ☐ Cultured Chorionic Villus ☐ DNA From _____

## CLINICAL INFORMATION *REQUIRED*

**Clinical findings/family history/test results** (attach copies if appropriate)

**Indication** ☐ Diagnostic ☐ Carrier

## Is patient/spouse/family member pregnant?

☐ No ☐ Yes **Check if relevant** ☐ Egg donor ☐ Sperm donor

**LMP**_____ **EDD**_____

## Genotypes

Proband _____

Mother _____

Father _____

## Diet

☐ Formula ☐ MCT Oil

☐ Breast Milk ☐ Hyperal

☐ Special _____

## Medications

☐ Anticonvulsants ☐ Antidepressants ☐ Antibiotics ☐ HAF/TPN

☐ Carnitine ☐ Oral Contraceptives ☐ Other _____

## Has Patient had any of the following?

☐ Transfusion ☐ Bone Marrow Transplant

## FOR LAB USE ONLY

**Rec/d**_____/_____/_____ **Unboxed By** _____

**Sender**_____

| TEMP | SPECIMEN | COLOR | # TUBES | | COMP. | INCOMP. |
|---|---|---|---|---|---|---|
| **R C F** | | | | **PT. DATA** | [ ] | [ ] |
| **R C F** | | | | **TEST DATA** | [ ] | [ ] |
| **R C F** | | | | **PHYSICIAN DATA** | [ ] | [ ] |
| **R C F** | | | | **BILLING DATA** | [ ] | [ ] |

**BILLING**

[ ] Facility Bill Acct # _____

[ ] Insurance Bill

[ ] Self-Pay

Hold Billing _____

QC _____

Reflex _____

Specimen _____

Accessioned by: Labeled by: Pickup:

## INFORMATION FOR HEALTH CARE PROVIDERS AND PATIENTS

Emory Genetics Laboratory retains patient samples indefinitely for validation, educational purposes and/or research. For molecular cytogenetic and some molecular genetic tests, submitted clinical information and test results are also included in HIPAA-compliant, de-identified public databases as part of the National Institute of Health's effort to improve diagnostic testing and our understanding of the relationships between genetic changes and clinical symptoms (for information about the molecular cytogenetic database, visit the consortium website at https://www.iscaconsortium.org/ and for information about the molecular genetic database refer to the individual test descriptions). Confidentiality of each sample is maintained. Patients may request to withdraw consent for the storage of their sample and/or use of the data by: 1) calling the laboratory at 1-855-831-7447 and asking to speak with a laboratory genetic counselor or 2) visiting our website at http://www.geneticslab.emory.edu/opt-out.

**[ ] Refusal for inclusion in these efforts may be indicated by checking this box. (If the box is not checked the data will be anonymized and used.)**

EMORY GENETICS LABORATORY

# CYTOGENETIC TEST REQUISITION FORM

2165 North Decatur Road Decatur, Georgia 30033
Phone: 855-831-7447 | 404-778-8499
Fax: 404-778-8559
http://geneticslab.emory.edu

Patient Name: Last_____ First _____ MI _____

Submit this completed payment options form with the specimen. Testing is not initiated until billing information is received. Billing policy information is available at http://geneticslab.emory.edu/billing.

## PAYMENT OPTIONS (please select one of the following options)

### 1 - ☐ INSTITUTION

*For new clients, to establish an institutional account, you must complete an Institutional Account Request Form **prior** to submitting an order. The form can be downloaded at http://geneticslab.emory.edu/billing. For any questions or to confirm whether you have an account or what your account number is, please contact our billing office at 404-778-8580 or by email at eglbilling@emory.edu.*

Institution _____ Account # _____

*The following information is not required if account number is provided above:*

Contact Name _____ Email _____

Billing Address _____

City _____ State _____ Zip _____

Phone_____ Fax _____

**EGL Billing Label**
*Please call to request labels*

### 2 - ☐ SELF PAY

☐ Cashier Check ☐ Visa ☐ MasterCard ☐ Discover

Amount $_____ (include discount if applicable)

Credit Card # _____ Expiration Date _____/_____

Cardholder Billing Address _____

City _____ State _____ Zip _____

Cardholder Phone _____

**Required for credit card payments**

_____
**Cardholder Printed Name as it Appears on Card**

_____
**Cardholder Signature**

### 3 - ☐ INSURANCE (Also includes Wellcare, Amerigroup, Peachstate for GA Residents, Medicare, and GA Medicaid). EGL does not accept any out-of-state Medicaid.

*A **legible** front and back copy of insurance card and insurance authorization must be included. A completed Advance Beneficiary Notice of coverage (ABN) is required for Medicare patients.*

**ICD9 Diagnosis Code(s) *Required** _____

**PRIMARY** Policyholder Name _____ DOB ____/____/_____

Relationship to the Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____ Gender ☐ Male ☐ Female

Insurance Co. Name _____ Policy No. _____ Group No. _____

Address _____

City _____ State _____ Zip _____

Phone _____ Authorization Number (Copy of authorization letter also required) _____

**SECONDARY** Policyholder Name _____ DOB ____/____/_____

Relationship to the Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____ Gender ☐ Male ☐ Female

Insurance Co. Name _____ Policy No. _____ Group No. _____

Address _____

City _____ State _____ Zip _____

Phone _____ Authorization Number (Copy of authorization letter also required) _____

**Authorization to assign benefits, accept financial responsibility, and disclose health records**

If I am entitled to benefits under the Medicare program, or any insurance policy or other health benefit plan, in consideration for services provided to me by EGL, I assign, transfer and convey the benefits payable under such program, policy or plan for such services to EGL. I authorize payment of benefits directly to EGL, with such benefits applied to my bill. I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me and I agree to pay charges not paid under this assignment, including any coinsurance amounts and deductibles and any charges for services deemed to be non-covered, not pre-certified or not preauthorized by my insurance plan. I understand that EGL is permitted to disclose my health information for purposes of payment of bills (if I filled out section 3 above), my continued care or treatment, and healthcare operations.

**Signature of Patient, Parent, or Guardian: (Required)**_____ **Date** _____/_____/_____

## INTERNATIONAL SAMPLES

**Payment in full must be made before samples will be processed.** Prepaid samples may receive a discount when required payment is received with the sample. Please visit our website for more information: http:geneticslab.emory.edu/billing/international. Payment by credit card can be indicated under option 2 above. Banker's checks or money orders must be made payable to Emory Genetics Laboratory. Please contact the EGL billing office for further arrangements or when you make an electronic fund payment at 404-778-8580 or eglbilling@emory.edu.

EMORY GENETICS LABORATORY

# CYTOGENETIC TEST REQUISITION FORM

2165 North Decatur Road Decatur, Georgia 30033
Phone: 855-831-7447 | 404-778-8499
Fax: 404-778-8559
http://geneticslab.emory.edu

Patient Name: Last_____ First _____ MI _____

For sequential testing, indicate in the 'Order' column, the numerical order for testing to be processed. Example: (1) MCADD Mutation Panel, (2) MCADD Gene Sequencing indicates that (1) MCADD Mutation panel will be run first. If NEGATIVE, (2) MCADD Sequencing will be added.
Note: Call to discuss prenatal molecular genetic testing with the laboratory genetic counselor PRIOR to sending a prenatal sample. 5 ml maternal blood in an EDTA (purple top) tube MUST accompany a prenatal specimen.

| | | CYTOGENETIC TESTING |
|---|---|---|
| **Order** | **Code** | **Chromosomal Microarray** |
| | VA | EmArray Cyto |
| | CMPRE | EmArray Cyto Prenatal (MCC Included) |
| | CMSNP | CytoScan SNP Array |
| | CMPOC | CytoScan SNP Array POC (MCC not included but recommended) |
| | CMCCS | Maternal Cell Contamination (MCC) |
| **Order** | **Code** | **Chromosome Analysis** |
| | CV | Chorionic Villi |
| | CA | Peripheral Blood, Age: 6 months and above |
| | CB | Peripheral Blood, Age: less than 6 months |
| | AD | Amniotic Fluid (includes AFP with reflex to ACHE) |
| | MM | Peripheral Blood, Mosaicism study |
| | CP | Fetal Blood (PUBS) |
| | CO | Products of Conception (CytoScan SNP Array POC recommended as first tier) |
| | CSKNC | Skin/Other Tissue |
| | FS | Targeted Family Member Study (attach report) |
| **Order** | **Code** | **FISH STAT** |
| | RS | Prenatal FISH - Aneuploidy (13,18, 21, X&Y) |
| | CFXYS | X and Y (ambiguous genitalia) |
| | CF22S | 22q11 microdeletion (DiGeorge, VCF) |
| | CF13S | Trisomy 13 |
| | CF18S | Trisomy 18 |
| | CF21S | Trisomy 21 |
| **Order** | **Code** | **FISH Standard** |
| | PA | FISH Analysis with Culture (Please indicate chromosomal abnormality and attach previous report _____) |
| | FI | FISH Analysis without Culture (Please indicate chromosomal abnormality and attach previous report _____) |
| | | Array Confirmation/Family Studies Custom Other: _____ |
| | | Wolf-Hirschhorn (4p-) |
| | | Cri-du-Chat (5p-) |
| | | Williams (7q11.2 del) |
| | | Prader-Willi/Angelman (Order after DNA methylation) |
| | | Smith-Magenis (17p11.2 del) |
| | | Miller-Dieker, lissencephaly (17p13) |
| | | 17q21 Microdeletion Syndrome |
| | | 22q11.2 deletion, DiGeorge/VCF (reflex test if heart defect on fetal u/s) |
| | TL | Telomere Panel |
| **Order** | **Code** | **Other Cyto Tests** |
| | TC | Tissue Culture |
| | PACHE | ACHE |
| | PAFP1 | AFP |

| | | MOLECULAR GENETIC TESTING |
|---|---|---|
| **Order** | **Code** | **Infertility** |
| | MG | Female Infertility Panel - Chromosomes, *FMR1* - related POF |
| | XM050 | Male Infertility Panel (Chromosomes, CF common mutation panel, Y-MicroDeletions) |

| | | OTHER TESTS |
|---|---|---|
| **Order** | **Code** | |
| | | Other Test *(Please Specify):* _____ |

Highlighted test names indicate panel tests.