

# 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 75390  
LAB PHONE: 214-648-0975  
LAB FAX: 214-648-0976  
CUSTOMER SERVICE: 214-633-5227  
TOLL FREE: 877-887-8136  
url: www.veripathlabs.com  
CLIA #: 45D-0861764  
CAP #: 2664213

**UT Southwestern**  
Medical Center

VERIPATH LABORATORIES

www.veripathlabs.com

## 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: \_\_\_\_\_

## 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: \_\_\_\_\_

## 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.

**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)  
 Cytogenomic microarray analysis  
 FISH only (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)  
**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: \_\_\_\_\_

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