Henry Ford Health System
CENTER FOR PRECISION DIAGNOSTICS

Pathology and Laboratory Medicine
Clinic Building, K6, Core Lab, E-655
2799 W. Grand Blvd.
Detroit, MI 48202
855.916.4DNA (4362)

GENETIC HEREDITARY DISORDER REQUISITION

Required Patient Information

Name: _____ Gender: M F

MRN: _____ DOB: MM / DD / YYYY

ICD10 Code(s): _____/_____/_____

ICD-10 Codes are required for billing. When ordering tests for which reimbursement will be sought, order only those tests that are medically necessary for the diagnosis and treatment of the patient.

Ordering Physician Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Billing & Collection Information

Patient Demographic/Billing/Insurance Form is required to be submitted with this form. Most genetic testing requires insuran ce prior authorization.
Due to high insurance deductibles and member policy benefits, patients may elect to self-pay. Call for more information (855.916.4362)

❑ Bill Client or Institution Client Name: _____ Client Code/Number: _____

❑ Bill Insurance Prior authorization or reference number: _____

❑ Patient Self-Pay Call for pricing and payment options Toll Free: 855.916.4362

Patient status at time of collection: ❑ Inpatient ❑ Outpatient Collection date: _____ Collection time: _____

Providers are responsible to obtain informed consent, as required by Michigan law, for predictive or pre-symptomatic genetic tests. Informed Consent form is attached to this requisition, please submit with sample.

Specimen/Source

❑ Peripheral blood in lavender (EDTA) top tube (minimum volume: 3 mL) | Specimen Stability: Ambient – 72 hours; Refrigerated – 1 week. **DO NOT FREEZE**

❑ *Extracted DNA:* ***ONLY ACCEPTED FROM CLIA CERTIFIED LABORATORIES***

Required Information

Will the results of the ordered test(s) affect treatment? ❑ Yes ❑ No

Is this treatable, preventable, or neither? ❑ Treatable ❑ Preventable ❑ Neither

Has there been any genetic counseling? ❑ Yes ❑ No

FOR CYSTIC FIBROSIS, FAMILIAL MEDITERRANEAN FEVER & SMA TESTING ONLY

Type of testing: ❑ Carrier Screen ❑ Diagnostic

Ethnicity: ❑ African American ❑ Arab American ❑ Ashkenazi Jewish ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Other: _____

Hereditary Testing (Germline)

All tests include pathologist interpretation at a separate, additional charge

❑ Cystic Fibrosis Screening Panel (81220, [reflex, if needed 81224 (Poly T)])

❑ Factor V (Leiden) (81241)
--Has the patient been diagnosed with a DVT? ❑ YES ❑ NO

❑ Familial Mediterranean Fever (81402)

❑ Fragile X Syndrome (81243)
--Is there a family history of Fragile X or metal retardation? ❑ YES ❑ NO

❑ Hereditary Hemochromatosis (HFE) (81256)

❑ Methylenetetrahydrofolate reductase (MTHFR) (81291)

❑ PGx- Cytochrome P450 2C19 (CYP2C19) (81225)

❑ Prothrombin 20210 G →A (81240)
-- Has the patient been diagnosed with a DVT? ❑ YES ❑ NO

❑ Spinal Muscular Atrophy (SMA) Carrier Screen (81329)

Other Molecular Testing

Send Additional Report To

Name:	
Address:	
Phone #:	Fax #:

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INFORMED CONSENT FOR GENETIC TESTING

PATIENT LAST NAME: (Please Print)	FIRST NAME:	MI:
DATE OF BIRTH: MM/DD/YYYY	PATIENT ID/MRN NUMBER:	

ORDERING PROVIDER INFORMATION (FULL LAST, FIRST):
Name:

Phone:

SAMPLE TYPE

- ❑ Amniotic fluid
- ❑ Blood
- ❑ Cheek swab
- ❑ Chorionic villus sample (CVS)
- ❑ Skin
- ❑ Tissue block
- ❑ Other_____

GENETIC TESTING REQUESTED FOR:

_____
(name of condition)

The intended purpose is (check all that apply):

- ❑ Carrier status
- ❑ Diagnostic
- ❑ Predictive
- ❑ Prenatal
- ❑ Pre-symptomatic
- ❑ Screening
- ❑ Other_____

1. I have been informed about the nature and the purpose of this genetic test.
2. I have received an explanation of the effectiveness and limitations of this genetic test.
3. I have discussed the benefits and risks of this genetic test with my physician and/or other health care professional. I understand some genetic tests can involve possible medical, psychological or insurance issues for my family and me.
4. I understand the meaning of possible test results and have been informed how I will receive the result.
5. I have been informed that genetic testing can sometimes reveal secondary findings-results that are not related to the purpose of testing. I have discussed with my health care professional if and/or how such results will be shared with me. I understand that it is up to me to decide whether I want secondary results reported back to me and what secondary results I want reported.
6. I have been informed who may have access to my biological sample, and that any leftover sample may be retained by the laboratory.
7. I have been informed who may have access to my genetic test result, which is part of my confidential medical record.
8. My questions have been answered to my satisfaction.
9. I understand that this consent form is intended to be used together with the patient information booklet that contains important information explaining the above eight items. I have read this consent form and understand that I can access the booklet electronically at: https://www.michigan.gov/documents/InformedConsent_69182_7.pdf
10. I received a copy of this form for my records.

I consent to have a sample taken for genetic testing on the above-named patient for the condition(s) listed above.

_____
Signature of Patient or Authorized Designee Date

Circle one: **Self** **Parent(s)** **Legal Guardian** **Durable Power of Attorney for Health Care**

Print Name of Physician or Authorized Delegee explaining the above information:

Signature of Authorized Person: Date: