CENTER for PRECISION DIAGNOSTICS

"Powering Precision Medicine"

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 Information

Patient Demographic/Billing/Insurance Form is required to be submitted with this form. Most genetic testing requires insurance 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

Providers are responsible to obtain informed consent, as required by Michigan law, for predictive or pre-symptomatic genetic tests. Informed Consent for Genetic Testing form is available on our website.

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 AND FAMILIAL MEDITERRANEAN FEVER TESTING:

TYPE OF TESTING: ❑ Carrier Screen ❑ Diagnostic

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

Specimen Submission Requirements

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

Hereditary Disorders (Germline)

All tests include pathologist interpretation at a separate, additional charge

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

❑ Prothrombin 20210 G →A (81240)

❑ Methylenetetrahydrofolate reductase (MTHFR) (81291)

❑ Spinal Muscular Atrophy (SMA) Carrier Screen (81401x2)

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

❑ Fragile X Syndrome (81243)
-Family history of Fragile X or mental retardation? ❑ Yes ❑ No

❑ Hereditary Hemochromatosis (HFE) (81256)

❑ Familial Mediterranean Fever (81402)

Other Molecular DNA/RNA Tests

Send Additional Report To

Name:

Address:

Phone #: Fax #: