

PEDIATRIC/ADULT CYTOGENOMICS 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 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 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 for Genetic Testing form is available on our website. Please submit with this requisition.

Specimen/Source

- Peripheral blood, sodium heparin tube (10mL preferred, 3mL minimum for infants) Skin biopsy (send in sterile media, Ringer's lactate or saline)
 Buccal – send two swabs; call lab for collection kit if needed Other: _____

Indication for Testing

- Congenital anomalies /Dysmorphic features (please describe): _____ History of pregnancy loss: Gr _____ Para _____ Ab _____
 Developmental delay/Intellectual disability Infertility
 Autism Spectrum disorders Primary amenorrhea
 Hypotonia Secondary amenorrhea
 Other: _____ Family history of: _____

Test(s) Requested

All tests include pathologist interpretation at a separate, additional charge.

- Microarray (Array-CGH) (81229) *for developmental delay, congenital anomalies, autism diagnoses*
 With reflex to Chromosome Analysis if normal (see Chromosome Analysis for CPT codes)
 Chromosome analysis (Blood: 88230, 88262, 88291; Skin biopsy: 88233, 88262, 88291)
 High Resolution (Chromosome analysis CPT codes + 88289)
 Y-chromosome microdeletion (81403)
 Fluorescent in situ hybridization (FISH) (88271x2, 88275, 88273)
Individual Probes
 22q11.2 DiGeorge Syndrome 5p Cri du Chat 17p11.2 Smith-Magenis X-linked Ichthyosis (STS) Yp11.3 SRY region
 7q Williams Syndrome 4p16.3 Wolf-Hirschhorn 17p13.3 Lissencephaly Xp22 Kallmann Syndrome X-Y

Other Testing

Send Additional Report To

Name: _____
 Address: _____
 Phone #: _____ Fax #: _____



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:	GENETIC TESTING REQUESTED FOR: <hr style="width:80%; margin: 0 auto;"/> <p style="text-align: center;">(name of condition)</p>	
<p style="text-align: center;">SAMPLE TYPE</p> <input type="checkbox"/> Amniotic fluid <input type="checkbox"/> Blood <input type="checkbox"/> Cheek swab <input type="checkbox"/> Chorionic villus sample (CVS) <input type="checkbox"/> Skin <input type="checkbox"/> Tissue block <input type="checkbox"/> Other _____	The intended purpose is (check all that apply): <input type="checkbox"/> Carrier status <input type="checkbox"/> Diagnostic <input type="checkbox"/> Predictive <input type="checkbox"/> Prenatal <input type="checkbox"/> Pre-symptomatic <input type="checkbox"/> Screening <input type="checkbox"/> 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: _____