HENRY FORD HEALTH
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)

PEDIATRIC/ADULT CYTOGENETICS 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: _____

NPI:_____

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)
❑ Buccal – send brush or swab; Call lab for collection kit if needed
❑ Extracted DNA – Source:_____
(provide CLIA certificate of lab that performed the DNA extraction)
❑ Skin biopsy (send in sterile media, Ringer's lactate or saline)
❑ Other: _____

Indication for Testing

❑ Congenital anomalies/Dysmorphic features (please describe):

❑ Developmental delay/Intellectual disability
❑ Autism Spectrum Disorders
❑ Hypotonia

❑ History of pregnancy loss: Gr _____ Para _____ Ab _____
❑ Infertility
❑ Primary amenorrhea
❑ Secondary amenorrhea
❑ Family history of:

❑ Other:

Test(s) Requested

Some testing includes pathologist interpretation at a separate, additional charge.

❑ Microarray (SNP Array) (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) **(requires one EDTA and one sodium heparin tube, ≥3mL each)**
❑ Fluorescent in situ hybridization (FISH) Constitutional/Reproductive Disorder Testing (88271x3, 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 #:

HENRY FORD HEALTH®

Consent for Genetic Testing

Place patient label here or fill out information below:

Patient Name: _____

Date of Birth: _____

MRN: _____

Office Use Only	
Ordering Provider Information (Last, First) Name: _____ Phone: _____	Genetic Testing Requested for: _____ (name of medical condition)
Sample Type: ❑ Amniotic fluid ❑ Blood ❑ Cheek swab ❑ Chorionic villus sample (CVS) ❑ Skin ❑ Tissue block ❑ Other_____	**The purpose is (check all that apply):** ❑ Carrier status ❑ Diagnostic ❑ Predictive ❑ Prenatal ❑ Pre-symptomatic ❑ Screening ❑ Other_____

I understand and agree to the following:

1. This form goes with an information booklet that has more information on genetic tests. I can find the booklet online at What Michigan Patients Need to Know Before Getting a Genetic Test or a written copy can be provided.
2. This genetic test has been explained to me. I understand why I am having this test done.
3. I understand what this genetic test may or may not be able to find.
4. I was able to talk to my doctor or other health care provider about the benefits and the risks of this test. I know that some genetic tests can involve health, mental health, or insurance issues for me or my family.
5. I understand what the results may mean and how I will get them.
6. I understand that genetic tests can sometimes find other results that have nothing to do with the original reason for the test. These are called secondary findings. I talked to my doctor or health care provider and I understand that I can decide if I want secondary findings shared with me.
7. I was told who may access my sample. I understand that any leftover sample may be kept by the laboratory and used for quality checks.
8. I was told who may see my test results. These results will be part of my health record.
9. I was able to talk to my doctor and have my questions answered about this test.
10. I was given a copy of this form for my records.

I have read this form, or it was read to me. I understand and agree to what it says. I agree to have a sample taken for genetic testing for the condition(s) listed above. If the signer is not the patient, the signer confirms that they are the patient's legally authorized representative.

Person signing form (circle one): Self Parent(s) Legal Guardian Durable Power of Attorney for Health Care

_____ _____ _____

Signature of Patient or Authorized Designee Time Date

_____ _____ _____

Signature of Physician or person explaining information Time Date