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)

# 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: _____

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 two swabs; call lab for collection kit if needed
❑ 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

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

❑ Microarray (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)
❑ FISH Constitutional/Reproductive Disorder Testing (88271x3, 88273x 88275
  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 #:

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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 testing.
2. I have received an explanation of the effectiveness and limitations of this genetic testing.
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 I.
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. If ordered by the ordering provider above, I authorize supplemental genetic testing to further aid in diagnosis, treatment and/or risk evaluation(s).
7. I have been informed who may have access to my biological sample, and that any leftover sample may be retained by the laboratory.
8. I have been informed who may have access to my genetic test result, which is part of my confidential medical record.
9. My questions have been answered to my satisfaction.
10. 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
11. 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: