

# PRENATAL 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

Maternal peripheral blood (required for MCC studies and Toxoplasma Serology, 5mL EDTA whole blood)

Amniotic fluid (15-20mL of fluid in 2-3 aliquots) Fluid color: \_\_\_\_\_

Chorionic villus (CVS)

Products of Conception (POC) (send in sterile media, Ringer's lactate or saline) Tissue source: \_\_\_\_\_

## Indication for Testing

Maternal Age: \_\_\_\_\_

Family history (specify) :

Abnormality on ultrasound (specify):

Other: \_\_\_\_\_

NIPT positive for:  +21  +18  +13  Other \_\_\_\_\_

## Pregnancy History

Gestational age: \_\_\_\_\_ weeks Last Menstrual Period (LMP): \_\_\_\_/\_\_\_\_/\_\_\_\_ Estimated Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gravidity: \_\_\_\_\_ Parity: \_\_\_\_\_ Abortus: \_\_\_\_\_

Biparietal Diameter or other: \_\_\_\_\_ mm Date ultrasound performed: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Prenatal Testing Options

Some testing includes pathologist interpretation at a separate, additional charge

AChE  Alpha-fetoprotein (AFP)  Cytomegalovirus (CMV) PCR  Toxoplasmosis PCR  Toxoplasma Serology (both amniotic fluid and maternal serum required)  
(with reflex to AChE and Fetal Hemoglobin if AFP MoM  $\geq$ 2.0) on amniotic fluid on amniotic fluid

Chromosome analysis (Amniotic Fluid: 88235, 88269, 88280, 88285, 88291; CVS: 88235, 88267, 88280, 88285, 88291; POC: 88233, 88262, 88291)

FISH Prenatal Aneuploidy Screen (88271x5, 88274x2) Note: requires additional 5mL of sample

Microarray (81229)

Direct  Cultured cells

Maternal Cell Contamination (MCC) Studies (81265)

## Additional Testing


## Send Additional Report To

Name:	
Address:	
Phone #:	Fax #:



CENTER FOR  
PRECISION DIAGNOSTICS

# 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 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](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: