



FETAL AND GENERAL CYTOGENETIC
REQUEST FOR CHROMOSOME/FISH/MICROARRAY TESTING

USE ONE FORM PER EACH SPECIMEN TYPE

Required Patient Information

Ordering Physician Information

Name: Gender: M F MRN: DOB: MM / DD / YY Insurance Authorization #: 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. ICD10 Code(s): Clinical Diagnosis:

This request to order tests from HFCDP certifies to HFCDP that (1) the ordering physician has obtained written informed consent from the patient as required by applicable state or federal laws for each test ordered and (2) the ordering physician has authorization from the patient permitting HFCDP to report results for each test ordered to the ordering physician. The tests below may include microdissection and/or reflex testing at a separate additional charge. All tests include pathologist interpretation at a separate additional charge.

General Genetic Analysis

Indication for Genetic Testing (check all that apply): Birth defects (please describe): Development delay Dysmorphic features (please describe) Family history of (name disorder): Hypotonia Infertility R/O Turner Syndrome Primary amenorrhea History of pregnancy loss: Gr Para Ab Pedigree or clinical history:

Specimen Type: transport specimens at room temperature

Peripheral blood (10 ml in sodium heparin; 3 ml for infants; plus 1 EDTA tube if ordering Microarray) Skin biopsy (send in sterile media, Ringer's lactate or saline) (DO NOT USE IODINE TO CLEAN AREA) Products of conception; tissue source: Maternal Cell Contamination (MCC) (CPT 81265) Other:

Test Requested

Microarray (Array-CGH), (CPT 81229) reflex to chromosome analysis if normal (use CPT codes below) Chromosome analysis (CPT 88261, 88280, 88285, 88230, 88291) High resolution chromosome analysis (CPT codes listed for "Chromosome analysis + 88289) Fluorescent in situ hybridization (FISH): (CPT 88271x2, 88275, 88273) DiGeorge/VCFS (22q11.2) Ichthyosis, X-Linked (Xp22.3) Other (specify):

*FISH for specific deletion syndromes is available. Check 'Other' and specify or call lab (1.855.916.4DNA) to make arrangements.

Fetal Analysis

Indication for Fetal Genetic Testing (check all that apply): Maternal Age Abnormality on u/s (specify): Family History (specify): Other: NIPT positive for: + 21 + 18 + 13 Other:

Specimen Type:

Amniotic fluid (15-20 ml of fluid in 2-3 aliquots), Fluid Color: Chorionic Villus Required Information: Pregnancy History Maternal Age: Gr Para Ab Gestational age: weeks LMP: EDC: BPD or other: mm Date u/s procedure performed:

Test Requested: Check if parents do not wish to learn sex of the fetus.

Chromosome analysis (CPT 88261, 88280, 88285, 88233, 88235, 88291) Alpha fetoprotein ACHE Special testing: Toxoplasmosis (maternal serum required) CMV Other (specify): FISH, Aneuploidy (CPT 88271x5, 88274x2) (requires an additional 5 ml of fluid) Reflex Microarray (CPT 81229) CGH (if normal chromosome analysis) Direct Microarray (CPT 81229) CGH (requires an additional 15 ml of amniotic fluid) Additional testing (specify):

*NOTE: Any special testing may require Maternal Cell Contamination - submit maternal EDTA blood sample.

Send Additional Report To (Name):

Lab Use ONLY:

Address: Phone Number: Fax Number: