

CYTOGENETICS TEST REQUISITION

SHIP TO: MEDICAL GENETICS LABORATORIES

Baylor College of Medicine
2450 Holcombe, Grand Blvd. - Receiving Dock
Houston, TX 77021-2024

!STOP IMPORTANT BILLING INFORMATION!

Indicate Institution Billing Code here: _____, OR
complete and fax billing information form (page 2 of requisition)
to 713-798-4187. **Samples received without the Institution
Code or Billing Form cannot be processed.**

FOR PRENATALS, PLEASE USE PRENATAL REQUISITION FORM.

PATIENT DATA

NAME (Last, First, Middle Initial): _____

DATE OF BIRTH (MM/DD/YY): ____/____/____

Please check one: MALE FEMALE UNKNOWN

HOSPITAL #: _____

ACCESSION #: _____

KCL #: _____

MEDICAL RECORD #: _____

REPORTING INFORMATION

PHYSICIAN/INSTITUTION: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE #: (____) _____ FAX #: (____) _____

Additional Reports to:

1. NAME: _____ FAX #: (____) _____

2. NAME: _____ FAX #: (____) _____

SAMPLE INFORMATION

DATE SAMPLE OBTAINED (MM/DD/YY): ____/____/____ TIME SAMPLE OBTAINED: _____

SAMPLE TYPE: BLOOD TISSUE OTHER: _____

TISSUE BIOPSY LOCATION: SKIN PLACENTA CORD PRODUCTS OF CONCEPTION (POC) OTHER: _____

IF PLACENTA OR POC, GESTATIONAL AGE: _____

INDICATION FOR STUDY

MUST check one or more below and be completed thoroughly to avoid delay in sample processing.

- | | | |
|---|--|---|
| <input type="checkbox"/> Ambiguous Genitalia | <input type="checkbox"/> Infertility | <input type="checkbox"/> Trisomy 18 |
| <input type="checkbox"/> Autistic Spectrum | <input type="checkbox"/> Klinefelter Syndrome | <input type="checkbox"/> Trisomy 21 |
| Developmental Delay/Mental Retardation | <input type="checkbox"/> Multiple Congenital Anomalies | <input type="checkbox"/> Turner Syndrome |
| <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> Multiple Miscarriages (x____) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dysmorphic Features | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> FMHX of Chromosomal Abnormality: _____ |
| <input type="checkbox"/> Failure to Thrive | <input type="checkbox"/> Testicular Failure | |
| <input type="checkbox"/> Fetal Demise | <input type="checkbox"/> Trisomy 13 | |

Previous Cytogenetic Results (if applicable): _____

Performed Where: _____

Family Members Studied By This Laboratory: _____ KCL #: _____

TEST REQUESTED (Check all appropriate boxes)

- 8600 Chromosome Analysis
- 8655 105K Chromosomal Microarray Analysis
- Parental Studies (requested in CMA report) - **Required:** Proband Name or KCL#: _____ Attach copy of the report

Available FISH Studies:

- | | |
|--|---|
| 8457 <input type="checkbox"/> Adrenal Hypoplasia Congenita | 8473 <input type="checkbox"/> Multiple Exostoses (<i>EXT2</i> , Potocki/Shaffer) |
| 8458 <input type="checkbox"/> Alagille Syndrome | 8474 <input type="checkbox"/> Neurofibromatosis |
| 8459 <input type="checkbox"/> Angelman Syndrome | 8456 <input type="checkbox"/> 1p36 Deletion |
| 8460 <input type="checkbox"/> Beckwith-Wiedemann Syndrome | 8475 <input type="checkbox"/> Pelizaeus-Merzbacher Disease(s) |
| 8462 <input type="checkbox"/> Charcot-Marie-Tooth (CMT1A) | 8476 <input type="checkbox"/> Prader-Willi Syndrome |
| 8464 <input type="checkbox"/> Cri-du-Chat Syndrome (5p-) | 8477 <input type="checkbox"/> Rubinstein-Taybi Syndrome |
| 8440 <input type="checkbox"/> DiGeorge Syndrome Panel (VCFS) (22q+10p) | 8478 <input type="checkbox"/> Smith-Magenis Syndrome |
| 8486 <input type="checkbox"/> DiGeorge Syndrome I (22q only) | 8479 <input type="checkbox"/> SOTOS Syndrome |
| 8465 <input type="checkbox"/> DiGeorge Syndrome II (10p only) | 8480 <input type="checkbox"/> SRY Analysis |
| 8466 <input type="checkbox"/> Glycerol Kinase Deficiency | 8481 <input type="checkbox"/> Telomeres Panel |
| 8467 <input type="checkbox"/> Hereditary Neuropathy with Liability to Pressure Palsies | 8482 <input type="checkbox"/> Trichorhinophalangeal Syndrome (<i>TRPS1</i>) |
| 8468 <input type="checkbox"/> Isolated Lissencephaly | 8450 <input type="checkbox"/> WAGR Syndrome |
| 8469 <input type="checkbox"/> Kallman Syndrome | 8483 <input type="checkbox"/> Williams Syndrome |
| 8430 <input type="checkbox"/> Langer Giedion (<i>EXT1/TRPS1</i>) Panel | 8455 <input type="checkbox"/> Wilms Tumor |
| 8470 <input type="checkbox"/> Microphthalmia with Linear Skin Lesions (MLS/MIDAS) | 8484 <input type="checkbox"/> Wolf-Hirschhorn Syndrome (4p-) |
| 8471 <input type="checkbox"/> Miller-Dieker Syndrome | 8485 <input type="checkbox"/> X-linked Ichthyosis (Steroid Sulfatase Deficiency) |
| 8435 <input type="checkbox"/> Multiple Exostoses (<i>EXT1/EXT2</i>) Panel | <input type="checkbox"/> Other (Please Specify): _____ |
| 8472 <input type="checkbox"/> Multiple Exostoses (<i>EXT1</i>) | |

BILLING INFORMATION FORM

STOP! ONE OF THE THREE FOLLOWING BILLING OPTIONS MUST BE INDICATED BELOW.
The Self-Pay option must include payment with sample. We require and provide insurance pre-verification service. Please fax the *Patient Insurance Verification Form* (available at www.bcmgeneticlabs.org) to 713-798-4187. If the Billing Information section is incomplete, the referring physician, hospital, or laboratory will automatically be billed, or sample processing suspended. Please forward billing questions to: medgenbilling@bcm.edu

PATIENT INFORMATION:

Name (Last, First, Middle Initial): _____
Address: _____
City, State, Zip: _____
Phone #: (____) _____ Email: _____

PAYMENT OPTIONS:

1. **Institution or referring MD Code (as assigned by BCM):** _____
(or) Institution Name: _____
Billing Address: _____
City, State, Zip: _____
Financial Contact: _____
E-mail (required): _____
Phone #: (____) _____ Fax #: (____) _____

2. **Self-Pay: Check, Money Order, or Credit Card payment must accompany sample.**
Credit Card (Please check one): AMEX Discover MC VISA
Valid Card #: _____ Exp date (mm/yy): ____/____ **CVC Code:** _____
Cardholder printed name: _____
Cardholder signature: _____

3. **Insurance:** Please refer to the Financial Policy at <http://www.bcm.edu/geneticlabs/billing.html> for complete insurance filing information and managed care contract list. Insurance is filed to our contracted carriers as a courtesy. Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. HMO policies must have required authorizations. We do not file out-of-state Medicaid. Prenatal CMA requires a prepayment amount. Contact medgenbilling@bcm.edu with questions.

ICD9 Diagnosis Code(s) must be provided or insurance cannot be filed: **ICD-9 CODE:** _____
 PPO, Commercial Insurance-provide Patient Insurance Verification form (PIVF) and front/back copy of card
 HMO-provide PIVF, authorization, front/back copy of insurance card
 Texas Medicaid/Texas Medicaid HMO-provide PIVF, authorization, front/back copy of Medicaid card

Insured Policyholder's Information:

Name: _____ Date Of Birth (mm/dd/yy): ____/____/____
Insured SS or ID #: _____ Gender (Please check one): M F
Authorization: _____
Relationship to Patient: _____
Insurance Name: _____
Employer: _____ Group #: _____
Insurance Address: _____
Insurance City, State, Zip: _____
Insurance Phone #: (____) _____

I authorize BCM Medical Genetics Laboratories to furnish any medical information requested on myself, or my covered dependents. In consideration of services rendered, I transfer and assign any benefits of insurance to BCM Medical Genetics Laboratories. I understand I am responsible for any co-pay, deductible, or non-covered service amounts. I understand I am fully responsible for payment of my account if the BCM Medical Genetics Laboratories is not a participant with my health plan, and my health plan does not fully reimburse my medical services due to lack of authorization or medical necessity.

Printed Name: _____

Signature: _____ Date (mm/dd/yy): ____/____/____