

PRENATAL TEST REQUISITION

PATIENT DATA

NAME: _____

Last First Middle Initial

DATE OF BIRTH: ____/____/____

HOSPITAL #: _____

ACCESSION #: _____

SHIP TO: MEDICAL GENETICS LABORATORIES
Baylor College of Medicine
2450 Holcombe, Grand Blvd. - Receiving Dock
Houston, TX 77021-2024

REPORTING INFORMATION:

PHYSICIAN CONTACT: _____ PHONE #: (____) _____

PHYSICIAN/INSTITUTION: _____

ADDRESS: _____

CITY, STATE, ZIP: _____ FAX #: (____) _____

Additional Reports to: 1. NAME: _____ PHONE #: (____) _____ FAX #: (____) _____

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

SAMPLE INFORMATION

CLINICAL:

Date of Procedure: _____

Performing Physician: _____

Dates to be used for AFAFP (pick ONE)*: LMP U/S

GA on U/S Date: _____ wks _____ days

U/S Date: ____/____/____

LMP Date: ____/____/____

* U/S dating will be used if no selection is made.

INDICATION:

- AMA
- Abnl Serum Screen: NTD Tri 21 Tri 18
 Other: _____
- Abnl US - specify: _____
- Multiple Ab
- Parental Concern
- Other Indication (Detail and attach reports): _____

SPECIMEN TYPE

- Amniotic Fluid _____cc
- Cultured Amniocytes
- CVS _____mg TA TC
- Cultured CVS
- Fetal Blood _____cc
- POC/Fetal Tissue
- Tissue Type: _____
- Parental Control Specimen
- Maternal Blood Paternal Blood
- Name: _____
- DOB (MM/DD/YY): ____/____/____

TEST REQUESTED

Notice: Prior to ordering any of the disorder tests below, you must call the lab and discuss the clinical history and sample requirements with a genetic counselor.

AVAILABLE CYTOGENETIC TESTING: Chromosome Analysis AFAFP AchE Aneuploidy FISH (24-48 hrs for 13, 18, 21, X and Y)*

For Prenatal CMA, use separate requisition

Please call to confirm. Sequencing tests are available for Known Familial Mutations only.

AVAILABLE DISORDER TESTING:

- | | | |
|--|--|---|
| <input type="checkbox"/> Adenosine Deaminase Deficiency | <input type="checkbox"/> Diamond-Blackfan Anemia <i>RPS19</i> | <input type="checkbox"/> Osteogenesis Imperfecta, AR <i>LEPRE1</i> |
| <input type="checkbox"/> ad-PEO 2 <i>ANT1/SLC25A4</i> | <input type="checkbox"/> Fabry Disease <i>GLA</i> | <input type="checkbox"/> Ornithine Transcarbamylase (OTC) Deficiency <i>OTC</i> |
| <input type="checkbox"/> ad-PEO 3 <i>TWINKLE/PEO1</i> | <input type="checkbox"/> Familial Adenomatous Polyposis <i>APC</i> | <input type="checkbox"/> Pelizaeus-Merzbacher <i>PLP1</i> |
| <input type="checkbox"/> Angelman Syndrome <i>UBE3A</i> | <input type="checkbox"/> Fatal Infantile Lactic Acidosis w/mtDNA Depletion <i>SUCLG1</i> | <input type="checkbox"/> <i>POLG1</i> Related Disorders |
| <input type="checkbox"/> APECED <i>AIRE</i> | <input type="checkbox"/> Focal Dermal Hypoplasia <i>PORCN</i> | <input type="checkbox"/> Purine Nucleoside Phosphorylase Deficiency |
| <input type="checkbox"/> Arginase Deficiency <i>ARG1</i> | <input type="checkbox"/> Fragile X Syndrome | <input type="checkbox"/> Pyruvate Dehydrogenase Deficiency <i>PDHA1</i> |
| <input type="checkbox"/> Argininosuccinic Aciduria <i>ASL</i> | <input type="checkbox"/> Guanidinoacetate Methyltransferase Deficiency <i>GAMT</i> | <input type="checkbox"/> Rett Syndrome <i>MECP2</i> |
| <input type="checkbox"/> ARX Related Disorders | <input type="checkbox"/> Hereditary Fructose Intolerance <i>ALDOB</i> | <input type="checkbox"/> RHD Molecular Typing |
| <input type="checkbox"/> Arylsulfatase A Deficiency <i>ARSA</i> | <input type="checkbox"/> Huntington Disease | <input type="checkbox"/> Rothmund-Thomson Syndrome <i>RECQL4</i> |
| <input type="checkbox"/> BCS1L Related Complex III Deficiency <i>BCS1L</i> | <input type="checkbox"/> Incontinentia Pigmentia | <input type="checkbox"/> <i>RRM2B</i> |
| <input type="checkbox"/> Carbamoyl Phosphate Synthetase I Deficiency <i>CPS1</i> | <input type="checkbox"/> L-Arginine:Glycine Amidinotransferase Deficiency <i>GATM</i> | <input type="checkbox"/> <i>SMCD COL10A1</i> |
| <input type="checkbox"/> Cartilage Hair Hypoplasia <i>RMRP</i> | <input type="checkbox"/> Lesch-Nyhan Disease <i>HPRT1</i> | <input type="checkbox"/> <i>SCO1</i> |
| <input type="checkbox"/> <i>CDKL5</i> Related Atypical Rett Syndrome <i>CDKL5/STK9</i> | <input type="checkbox"/> Leukoencephalopathy <i>VWM EIF2B5</i> | <input type="checkbox"/> <i>SCO2</i> |
| <input type="checkbox"/> Charge Syndrome <i>CHD7</i> | <input type="checkbox"/> Lowe Syndrome <i>OCRL1</i> | <input type="checkbox"/> Spinocerebellar Ataxia 1 (SCA1) |
| <input type="checkbox"/> Citrin Deficiency <i>SLC25A13</i> | <input type="checkbox"/> MNGIE Syndrome (Thymidine Phosphorylase) <i>TP</i> | <input type="checkbox"/> Spinocerebellar Ataxia 10 (SCA10) |
| <input type="checkbox"/> Citrullinemia I ASS | <input type="checkbox"/> <i>MPV17</i> | <input type="checkbox"/> <i>SURF1</i> |
| <input type="checkbox"/> Cleidocranial Dysplasia <i>RUNX2</i> | <input type="checkbox"/> Mucopolysaccharidosis Type I <i>IDUA</i> | <input type="checkbox"/> Thymidine Kinase <i>TK2</i> |
| <input type="checkbox"/> Coenzyme Q10 Deficiency <i>COQ2</i> | <input type="checkbox"/> Mucopolysaccharidosis Type II <i>IDS</i> | <input type="checkbox"/> X-linked Ocular Albinism <i>GPR143</i> |
| <input type="checkbox"/> Coenzyme Q10 Deficiency <i>PDSS1</i> | <input type="checkbox"/> Myotonic Dystrophy | <input type="checkbox"/> X-linked Angelman-like Syndrome <i>SLC9A6</i> |
| <input type="checkbox"/> Coenzyme Q10 Deficiency <i>PDSS2</i> | <input type="checkbox"/> Nail-Patella Syndrome <i>LMX1B</i> | X-linked Ichthyosis (STS Deficiency) |
| <input type="checkbox"/> <i>COX10</i> | <input type="checkbox"/> Noonan Syndrome <i>PTPN11</i> | <input type="checkbox"/> FISH <input type="checkbox"/> Biochemical |
| <input type="checkbox"/> Cystic Fibrosis <i>CFTR</i> | <input type="checkbox"/> Optic atrophy type 1 <i>OPA1</i> | <input type="checkbox"/> Wolman Disease <i>LIPA</i> |
| <input type="checkbox"/> DGUOK (Deoxyguanosine Kinase) | <input type="checkbox"/> Osteogenesis Imperfecta, AR <i>CRTAP</i> | |

POLICY INFORMATION

***TURNAROUND TIME NOTICE:** Samples received after 3 pm may be subject to an increase in turnaround time.

REFLEX POLICY: The following will be performed by reflex at no additional charge; AchE when AF-AFP is elevated; Fetal HGB when AF-AFP is elevated and amniotic fluid is bloody; CF5T when R117H CF mutation is present.

NOTICE FOR PRENATAL BIOCHEMICAL AND DNA TESTS: Please be aware that our specimen requirements and quality control measures are compliant with American College of Medical Genetics (ACMG) Standards and Guidelines for Clinical Genetics Laboratories. While these requirements are intended to provide the highest level of assurance that a single laboratory can offer, the ideal practice to assure the accuracy of prenatal diagnostic testing is through duplicate testing conducted by independent laboratories. We recommend that referring medical professionals make the necessary arrangements for these two independent analyses for their patients prior to performing the prenatal diagnostic procedure.

Physician/Counselor Acknowledgement: _____ 11/1/2008

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): ____/____/____