GENETICS LABORATORY
CYTOGENETICS REQUISITION FORM
CONSTITUTIONAL DISORDERS

PLEASE COMPLETE ALL FORMS AND SEND WITH PATIENT SAMPLE

Ship To: O'Donoghue Research Bldg.
1122 NE 13 Street, Suite 1400
Oklahoma City, OK 73104
Phone: 405-271-3589
Fax: 405-271-7117
After hours phone: 405-496-9514

Courier Service in OKC metro area call Rapid Transit 793-1122 for specimen pickup

REFERRING PHYSICIAN/FACILITY

Physician Name____

NPI____

Phone(____)_________________ Fax (___)_________________________

Genetic Counselor ______________________ Phone(___)_________________

Laboratory/Institution____

Address____

City___________________________ State_____________ Zip_____

Phone(____)_________________ Fax (___)_________________________

PATIENT AND BILLING INFORMATION

Patient Name (last,first,m.)____

Parent Name (if patient is a minor)_______________________________________

DOB_______________ SSN_____________________ MRN__________________

Sex: ☐ Male ☐ Female ☐ Ambiguous ☐ Unknown ☐ Inpatient ☐ Outpatient

Ethnicity of patient (check all that apply)
☐ African-American ☐ Asian ☐Caucasian/NW European ☐ E. Indian
☐ Hispanic ☐ Jewish-Ashkenazi ☐ Jewish-Sephardic ☐ Native American
☐ Native Hawaiian/Other Pacific Islander ☐ Other________________

Patient's Address____

City__________________________________ State_______ Zip Code__________

SPECIMEN/CLINICAL INFORMATION

Diagnosis/Clinical Findings/Family History ____

You may also list ICD-10 codes

Date Specimen Collected_______________ Time________

SPECIMEN TYPES & COLLECTION REQUIREMENTS

☐ **Peripheral Blood** ☐ **Cord Blood** ☐ **Pellet** previous lab # ______________

3-5 cc in large sodium heparin tube (dark green top), mix well. Keep specimen at room temperature or cooler, do not freeze. No additional blood needed for FISH

☐ **Amniotic Fluid** ☐ **CVS** ☐ **Fetal Urine**

DO NOT TRANSPORT SPECIMENS IN SYRINGES!

Collect 15-20 cc and transfer to sterile centrifuge tubes. For FISH studies an additional 5 cc of fluid is required. Keep specimen cool but do not freeze.

Gestational age by: ultrasound_________ or LMP__________

Gravida__ __ Para__ __ __ __

☐ **Skin Biopsy** ☐ **Products of Conception** ☐ **Placenta** ☐ **Fetal Tissue**

2-3 cc/1-2cm2 in transport media or sterile normal saline. Do not use formalin and do not use a fixative. Observe sterile technique. Keep cool, do not freeze

☐ **Unstained Slides (FISH testing only)**

☐ **Buccal swab (FISH testing only)** Collect 2 specimens w/nylon brushes. Keep fresh sample at room temperature.

TEST INFORMATION

Test Type

☐ **Karyotype** (routine chromosome analysis)

☐ **Karyotype and FISH Select a FISH probe**

☐ **FISH only Select a FISH probe** If previous chromosome studies have been done. provide a copy of these results if performed at another lab.

☐ **Culture only** ____

FISH Probes

☐ Trisomy of ________
☐ Screen for trisomies of 13, 18, 21, X and Y
☐ 1p36 deletion syndrome
☐ Angelman syndrome
☐ Cri-du-Chat syndrome
☐ Kallmann syndrome
☐ Miller-Dieker syndrome
☐ Smith-Magenis syndrome
☐ Sotos syndrome
☐ Turner syndrome
☐ Wolf-Hirschorn syndrome
☐ CHARGE syndrome
☐ DiGeorge syndrome 22q11.2
☐ Klinefelter syndrome
☐ Prader-Willi syndrome
☐ Sex chromosomes
☐ SRY gene deletion
☐ Williams syndrome

* **If you would like to order a molecular, sequencing, or cancer test please refer to the correct requisition forms. This is not the correct form to order those tests.**

ADDITIONAL REPORT

Physician/Facility____

Phone_(___)____________________ Fax_(___)________________

Address____

____

GENETICS LABORATORY USE ONLY

Laboratory Number____________________________________

Date & Time of Pick-Up/Delivery__________________________

Location____

Initials_________ Check-in__________

Additional Specimen(s) sent for this patient______________________

Previous Lab Number__________________________________

Genetics Laboratory
Billing Information Form

Patient Name LAST_______________________________________ FIRST___________________________________ MI______

YOU MUST CHOOSE ONE OF THE THREE BILLING OPTIONS LISTED BELOW.
PLEASE FORWARD ALL BILLING QUESTIONS TO DANIELLE OTIS AT DOTIS@OUHSC.EDU OR CALL 405-271-3589 OPT 4
AT THIS TIME WE DO NOT ACCEPT OUT-OF-STATE MEDICAID

PAYMENT OPTION 1-INSTITUTION

INSTITUTION NAME ____

BILLING ADDRESS____

CITY, STATE, ZIP ____ CONTACT NAME___________________________________

PHONE NUMBER____________________ FAX NUMBER____________________ CONTACT EMAIL ADDRESS ________________________________

PAYMENT OPTION 2-SELF PAY (PAYMENT MUST BE SENT WITH SAMPLE)

☐ **CREDIT CARD** (CIRCLE ONE) AMEX DISCOVER VISA MASTERCARD AMOUNT TO CHARGE_______________________________________

VALID CARD # ____ EXP DATE____

CVV CODE _____________ CARDHOLDER PRINTED NAME____

BILLING ADDRESS ____ CITY, STATE, ZIP____

CARDHOLDER SIGNATURE ____

☐ **CHECK #** ___________________________ AMOUNT ENCLOSED____

PAYMENT OPTION 3-INSURANCE PROVIDE A LEGIBLE COPY OF THE FRONT & BACK OF INSURANCE CARD
PLEASE NOTE: OUR FACILITY WILL CONFIRM COVERAGE AND VERIFY WHETHER OR NOT THE TEST(S) ORDERED ARE COVERED BY YOUR PLAN.
OUR OFFICE CAN ALSO OBTAIN PRE-AUTHORIZATION FROM THE INSURANCE PLAN.

PRIMARY INSURANCE POLICYHOLDER NAME ____ POLICYHOLDER DOB_____________________

PRIMARY POLICYHOLDER SS# ___________________________________ GENDER: ○ M ○ F EMPLOYER___________________________________

RELATIONSHIP TO PATIENT____________________________ POLICY # ____

GROUP #____ INSURANCE CO. NAME ____

PHONE ____ CLAIMS ADDRESS ____

CITY, STATE, ZIP_______________________________________ INSURANCE AUTH #____

SECONDARY INSURANCE POLICYHOLDER NAME ___________________________________ POLICYHOLDER DOB____________________________

SECONDARY POLICYHOLDER SS# _________________________________ GENDER: ○ M ⊙ F EMPLOYER____________________________________

RELATIONSHIP TO PATIENT_____________________________ POLICY # ____

GROUP #____ INSURANCE CO. NAME ____

PHONE ____ CLAIMS ADDRESS ____

CITY, STATE, ZIP_______________________________________ INSURANCE AUTH #____

I CONSENT TO HAVE THE TEST(S) LISTED ON THE PREVIOUS PAGE PERFORMED. I AUTHORIZE THE UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY 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 UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY. I UNDERSTAND I AM RESPONSIBLE FOR ANY CO-PAY, DEDUCTIBLES, OR NON-AUTHORIZED SERVICES AND REMAINING BALANCES AFTER INSURANCE REIMBURSEMENT. I UNDERSTAND I AM FULLY RESPONSIBLE FOR PAYMENT OF MY ACCOUNT IF THE UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY IS NOT A PARTICIPANT WITH MY HEALTH PLAN OR MY HEALTH PLAN DOES NOT FULLY REIMBURSE MY MEDICAL SERVICES DUE TO LACK OF AUTHORIZATION OR MEDICAL NECESSITY.

PRINTED NAME _______________________________________ SIGNATURE____ DATE ______________