CONSTITUTIONAL (BLOOD) TEST REQUISITION FORM

Cytogenetic Laboratories
Indiana University School of Medicine
975 W Walnut Street IB-350
Indianapolis, IN 46202
317/274-2243 (Office) 317/278-1616 (Fax)

Patient Laboratory Label

CAP#: 16789-30 **CLIA#: 15D0647198**

1) PHYSICIAN(S):

Ordering Physician: _____
Address: _____

City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____

Primary Physician: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____

FOR LABORATORY USE ONLY:

Date Received: ____/____/____ Family #: _____
Time Received: ____:____am/pm Proband: ☐ Not Proband: ☐
Received By: _____

☐ BL ☐ FISH x _____ Probes ☐ FISH **ONLY**

☐ CMA ☐ MO ☐ C-banding ☐ Q-banding ☐ NOR-staining

Handling Charge x _____ ☐ Handling **ONLY**

Lab Comment(s): Vacs: _____ green _____ purple; Other _____

2) PATIENT INFORMATION:

Patient Name: _____
Last Name *First Name* *Middle Initial*

Address: _____
Street *City* *State* *Zip Code*

Hospital: _____ Medical Record #: _____

Date of Birth: ____/____/____ Patient's Sex: ☐ Male ☐ Female Patient Recently Pregnant: ☐ Yes ☐ No
Month Day Year

3) CLINICAL INFORMATION:

Collection Date: ____/____/____ Collection Time: ____:____ AM Collected By: _____
Month Day Year

☐ Blood ☐ Cord Blood Recently transfused: ☐ Yes ☐ No Date: _____ ☐ Buccal Swab (CMA only)

4) REFERRING DIAGNOSES *(please check all that apply)*:

☐ Ambiguous Genitalia
☐ Autism Spectrum Disorder
☐ Congenital Heart Defect
☐ Developmental Delay
☐ Down Syndrome
☐ Dysmorphic Features
☐ Failure to Thrive
☐ Hypotonia
☐ Multiple Congenital Anomalies
☐ Recurrent Pregnancy Loss
☐ Seizures
☐ Short Stature
☐ Other _____
☐ ICD-10 Code: _____
☐ Family History of Chromosome Abnormality **(Please provide name, DOB, MRN)** _____

5) REQUESTED TESTING:

☐ Standard Chromosome Analysis/Karyotype
-- 1 Sodium Heparin Tube (Dark Green-top); 3 mL (infants), 7 mL (adults)

☐ Rapid Chromosome Analysis/Karyotype:
-- Preliminary result in 48-72 hours
-- 1 Sodium Heparin Tube (Dark Green-top); 3 mL (infants)

☐ Peripheral Blood or Skin Biopsy for Fanconi Anemia Breakage Study using DEB
-- 2 Sodium Heparin Tubes (Dark Green-top); 7-12 mL

☐ Standard Chromosome Analysis **with** Reflex to Microarray (CMA):
-- Reflexes if karyotype is normal.
*-- 1 EDTA Tube (Purple-top); **minimum** 1 mL*
-- 1 Sodium Heparin Tube (Dark Green-top); 3 mL (infants), 7 mL (adults)

☐ Fluorescence In Situ (FISH) Analysis *(Select Probe below)*
-- 1 Sodium Heparin Tube (Dark Green-top); 2 mL

☐ Aneuploidy FISH Full Panel (13, 18, 21, X/Y)
☐ Aneuploidy FISH 13/21 Only
☐ Aneuploidy FISH 18/X/Y Only
-- Results in 24-72 hours
*-- 1 Sodium Heparin Tube (Dark Green-top); 2 mL, **minimum** 1 mL*

☐ Constitutional Chromosomal Microarray (CMA) - Peripheral Blood is preferred.
Two tubes of blood are required:
-- 1 EDTA Tube (Purple-top); minimum 1 mL
*-- 1 Sodium Heparin Tube (Dark Green-top); **minimum** 1 mL*
Buccal Swabs are also accepted (contact lab for collection kit).

☐ Parent/Family Member Studies as Follow-up to CMA
(Test performed based on recommendations in proband's CMA report.)
--1 Sodium Heparin Tube (Dark Green-top); 2 mL
Please provide previous patient information (Name, MRN, DOB)
_____

6) MICRODELETION FISH ANALYSIS REQUESTED:

☐ Cri-Du Chat ☐ DiGeorge (VCFS) ☐ SRY ☐ Williams

7) PATIENT FINANCIAL AUTHORIZATION/INSURANCE BENEFIT VERIFICATION:

IMPORTANT: Patient and health care providers desiring private insurance billing MUST complete and submit the signed Patient Financial Authorization/Insurance Benefit Verification portion prior to or at the time of sample submission. *Failure to do so will delay testing/results*.

Patient Financial Authorization (Authorization To Assign Benefits And Financial Responsibility For My Account)

I assign and authorize insurance payments to Indiana University Medical Genetics Services Inc. I understand my insurance carrier may not approve and reimburse my medical genetic services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, or medical necessity or otherwise. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles (not to exceed $5,000) except where my liability is limited by contract or State and Federal law. A duplicate or faxed copy of this authorization is considered the same as the original document.

Signature of Patient or Guardian | Printed Name of Patient for Guardian | Date

Patient Authorization for Insurance Benefit Verification

If the prior-authorization has been completed by the health care provider, please provide the information below to proceed with testing.
Prior-Authorization Number:

Authorization To Contact Health Insurance Carrier And Release Confidential Medical Information

I understand Indiana University Medical Genetics Services Inc. may contact my insurance carrier regarding coverage of genetic testing. I authorize the disclosure of insurance benefit coverage and payment information to Indiana University Medical Genetics Services Inc. I authorized my physician or other medical entity to release confidential medical information to I.U. Genetic Testing Laboratories concerning my medical history. I authorize Indiana University Medical Genetics Services Inc. to release confidential medical information to my health insurance carrier to facilitate reimbursement of my medical fees.

Signature of Patient or Guardian | Printed Name of Patient for Guardian | Date

Health Care Providers Please Provide the Following:

1. Patient Demographic Sheet
2. Enlarged Copy of Insurance Card/s (Front and Back)
3. Patient's Insurance: Policy/Identification #: _____ Group #: _____
   Insurance/Managed Care plan: _____
   Street Address: _____ City: _____ State: _____ Zip: _____
   Insurance Phone Number: _____ Insurance FAX Number: _____
   Relationship to Insured: ☐ Self ☐ Spouse ☐ Other: _____
4. Please Indicate the Following: ☐ Bill Patient/Self Pay (*Demographic Sheet Required*) ☐ Bill Hospital
5. The Above Portion Signed by the Patient/Guardian
6. The Diagnosis and ICD-9 Codes: _____

8) SPECIMEN COLLECTION REQUIREMENTS

Specimen	Collection	Container(s)	Instructions
Peripheral Blood for Chromosome Analysis	7-10 mL whole blood (adults) 2-4 mL whole blood (infants)	Dark Green-top, Sodium Heparin tube.	**Keep at room temperature.** If post-mortem, obtain by cardiac puncture within 1 hour.
Peripheral Blood for Microarray (CMA)	3-5 mL whole blood (per tube, adults) 1-2 mL whole blood (infants)	1 Purple-top, EDTA tube **AND** 1 Dark Green-top, Sodium Heparin tube.	**Keep at room temperature.**
Buccal Swab for Microarray (CMA)	Refer to instructions printed on collection kit.	ORAcollect•Dx OCD-100	Refer to instructions printed on collection kit.
Peripheral Blood for Fanconi Anemia Testing	7-12 mL whole blood	Dark Green-top, Sodium Heparin tube.	**Keep at room temperature.**
Cord Blood for Chromosome Analysis	2-4 mL	Dark Green-top, Sodium heparin tube.	**Keep at room temperature.**
DNA for Microarray (CMA) --Extraction must occur in a CLIA-certified lab.	Concentration of DNA $\geq$ 50 ng/µl Amount of DNA $\geq$ 20 µl	Screw-cap tube.	**Keep at room temp.** Quality of CMA data may be impacted if DNA is extracted by outside lab. For best results, provide fresh blood specimen.

9) SPECIMEN HANDLING REQUIREMENTS

- Use sterile technique; close all containers tightly.
- **Do not freeze any specimen type.**
- Label all containers and requisition forms with patient name, MRN, date of collection, and physician name.
- **Specimens should be received within 24 hours of collection.**