PRENATAL/TISSUE TEST REQUISITION FORM

Cytogenetic Laboratories

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

317/274-2243 or 317/274-2246 (Lab)

CAP#: 16789-30 CLIA#: 15D0647198

Cytogenetic Lab Use Only

1) PHYSICIAN(S):

Referring Physician:_____
Institution:_____
Phone/Pager:_____ Fax:_____

Genetic Counselor: _____
Phone/Pager:_____ Fax:_____

Additional
Recipients:_____
Phone/Pager:_____ Fax:_____

FOR LABORATORY USE ONLY:

Date Received: _____/_____/_____ Family #: _____
Time Received: _____:_____am/pm Proband: ☐ Yes ☐ No
Received By _____

AM: ☐ CV: ☐ TI: ☐ CMA: ☐ CMA+5: ☐
AneuVysion FISH: ☐
Handling Charge: ☐ x _____ Handling **ONLY**: ☐

Lab Comment(s):

2) PATIENT/CLINICAL INFORMATION

(Fetus of) _____ _____ _____ _____ _____ Sex: ☐Male ☐Female
Patient Last Name Patient First Name Date of Birth (MM/DD/YY)

Address: _____ Hospital: _____ MRN: _____

Date of Collection (MM/DD/YY) _____, _____, _____Time:_____ Estimated Gestational Age (EGA)_____ By ☐LMP or ☐ Ultrasound

Was pregnancy achieved through ART? If so, how: ☐Egg Donor ☐Sperm Donor ☐IVF ☐ICSI

Sample Type:

☐Amniotic Fluid _____ cc ☐Products of Conception (POC): ☐Villi ☐Placenta ☐Fetal, Source: _____ ☐Other: _____

☐CVS _____ mg (☐TA ☐TC) ☐Skin Biopsy (Non-fetal), Source: _____ ☐Other, Describe: _____

☐Maternal Blood for MCC (3-5cc in EDTA tube, **Required** for prenatal CMA) _____ cc

☐Paternal Blood (3-5cc in EDTA tube, Requested for prenatal CMA) _____ cc Paternal Name/Date of Birth _____

3) REFERRING DIAGNOSES (please check all that apply):

☐ Advanced maternal age
☐ Abnormal NIPT (attach report): ☐ T13 ☐ T18 ☐ T21 ☐ MONX ☐ Other _____
☐ Abnormal maternal serum screen: ☐ T13 ☐ T18 ☐ T21 ☐ MONX ☐ Other _____
☐ Abnormal ultrasound, describe: _____
☐ Family history of chromosome abnormality, describe: _____
☐ Fetal demise ☐ Recurrent spontaneous abortion/miscarriage
☐ Parental concern ☐ ICD10 Code/Other: _____

PATIENT LABEL

4) REQUESTED TESTING (please check all that apply):

Amniotic Fluid and CVS Test Options:

☐ Chromosome analysis
☐ Chromosomal Microarray Analysis (CMA) with abbreviated chromosome analysis
  ☐ Maternal cell contamination studies included: Maternal blood sample (3-5cc in EDTA tube) required.
☐ Aneuploidy FISH (13, 18, 21, X, Y). Chromosomes or CMA required.
☐ AFP (amniotic fluid only)
☐ ACHE reflex (amniotic fluid only)
☐ Save cultured cells for send-out testing

Products of Conception (POC)/Skin Biopsy Test Options:

☐ Chromosome analysis
☐ Chromosomal Microarray Analysis (CMA) (POC only)
☐ Chromosome analysis with Reflex to CMA (POC only)
☐ Chromosome analysis to rule out mosaicism (skin biopsy only)
☐ Save cultured cells for send-out testing
☐ Maternal Cell Contamination Studies (RECOMMENDED for POC CMA):
  Maternal blood sample (3-5cc in EDTA tube) required

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6) SPECIMEN COLLECTION REQUIREMENTS

Specimen	Collection	Container(s)	Instructions
Amniotic Fluid	20-25 mL of fluid at ≥16 weeks of gestation (30 mL if additional studies are ordered). Discard first 2-3 mL to avoid maternal cell contamination. Place remaining fluid in 3-4 aliquots, labeled 1st, 2nd, etc.	Sterile Corning centrifuge tubes can be provided upon request. For bloody specimens, use Dark Green-top sodium heparin tubes. These tubes are also available upon request by calling the lab.	**Refrigerate.** **Do not centrifuge.**
Chorionic Villus (CVS)	20-30 mg (50 mg if additional studies are ordered).	Transport media will be provided upon request by calling the lab.	**Refrigerate.**
Products of Conception (POC)	5-10 mm^3 Villi from the placenta is the preferred sample type. Fetal cartilage, membranes, and tendon will also be accepted.	Transport media will be provided upon request by calling the lab. If not available, use a sterile screw-top container with sterile media.	**Refrigerate.** **Do not send entire fetus.**
Skin Biopsy (non-fetal)	Skin punch or surgery skin specimen	Transport media will be provided upon request by calling the lab. If not available, use a sterile screw-top container with sterile media.	**Refrigerate.**

7) SPECIMEN HANDLING REQUIREMENTS

- Collect all specimens aseptically.
- **Do not freeze any specimen type.**
- **Do not place specimens in formalin or any other fixative.**
- Keep all specimens refrigerated until transport. **Specimens should be received within 24 hours of collection.**
- Label all containers and requisition forms with patient name, MRN, date of collection, and physician name.
- MATERNAL samples are REQUIRED to accompany the fetal sample for prenatal CMA. Paternal specimens are requested.
- MATERNAL samples are RECOMMENDED to accompany the fetal sample for POC CMA.

Shipping Instructions:

- Please enclose the cytogenetic test requisition and consent form with the sample. All required information must be completed before sample can be processed.
- Send specimens in a plastic zipper biohazard bag and place paperwork in the side pocket of the bag or in a separate bag or envelope. **Do not place paperwork in the same bag as the specimen**.
- Place specimen bag in Styrofoam mailer and ship at room temperature by overnight Federal Express to arrive Monday through Friday. Saturday delivery is available. Please call for specific information and instructions for Saturday delivery.
- Outside of Indianapolis, please ship by FedEx or other overnight courier to:

  IU Cytogenetic Laboratories
  Department of Medical and Molecular Genetics
  975 W. Walnut St.
  IB 350
  Indianapolis, IN 46202
- Please call the laboratory and alert us that a specimen is en route: (317) 274-2243

8) PATIENT BILLING INFORMATION:

☐ Bill Patient's Insurance: Policy #: _____ Group #: _____

Insurance/Managed Careplan: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Other: _____ Insured's Social Security #: _____

☐ ***OR*** Copy of patient's insurance card attached

☐ Bill Medicare: _____

☐ Bill Medicaid: _____

☐ Bill Patient/Self-Pay *(Please Attach Patient Demographic Sheet)*

☐ Bill Hospital: _____