UR MEDICINE | Labs

# Specimens:	Blue:	Lav:	Red:	SST:	Grn:	Gray:	Urine	Micro:
Collect Date:	Time:	By:	Depot:	ABN Signed: ☐				
MR #:	A #:							

STAT

REQUIRED (PRINT OR PATIENT LABEL)

Name(Last, First, MI)

Date of Birth | Sex:(circle) M F

Street Address

Street Address 2

City, State, Zip

Phone Number | Client Number

Indicate primary (1) and secondary (2) insurance

__Blue Cross/Shield __Child Health Plus __MVP

__Blue Choice __Medicaid __MVPG

_Medicare Blue Choice __Medicare __Aetna

__Other _____

1. Primary Contract #: _____

Subscriber's Name: _____

Relationship to Subscriber: _____

2. Secondary Contract _____

Subscriber's Name: _____

Relationship to Subscriber:

Practice Name_____

Address _____

Address2 _____

City, State, Zip _____

Phone# _____

Ordering Provider _____

Phone Results to: Fax Results to:

Ordering Provider's Signature

Date of Signature

Diagnosis Mandatory: Signs/Symptoms or ICD9 Codes

If ordered for screening, list test name here and write "SCREENING" after it

Send Additional Reports To: (Full Name/Address)

Compliance is Mandatory and Regulated. For the laboratory to bill properly and receive payment for tests ordered on Medicare Beneficiaries, specific ICD-9 code(s) or a descriptive diagnosis must be included on each patient for each test ordered.It is critical that the diagnosis provided to the lab is consistent with those recorded in the patient medical record on the date of service.

Cytogenetics Laboratory 275-5859

_____

CONSTITUTIONAL CYTOGENETIC ANALYSIS

SPECIMEN TYPE

☐ Amniotic Fluid ☐ CVS Sterile Container/Media/Rm Temp

Date of Ultrasound ___/___/___ GA on Date of Ultrasound _____weeks _____days

☐ Peripheral Blood (SMH) Lavender/Green Top/Rm Temp (2-5 mL)

☐ Skin Biopsy Sterile Container/Media/Rm Temp

☐ POC Sterile Container/Media/Refrig.

INDICATION(S) FOR TEST

☐ Abnormal Maternal Serum/First Trimester Screen - specify _____
☐ Abnormal Ultrasound
☐ Autism
☐ Biochemical Testing - specify:_____
☐ Congenital Anomalies - specify: _____
☐ Developmental Delay ☐ MR
☐ Dysmorphic Features
☐ Family History of Chromosome Abnormality - specify_____
☐ Failure to Thrive
☐ History of SAB
☐ Maternal Age
☐ Other - specify:_____

TEST(S) * Patient Consent required

☐ Chromosome G-Banding Analysis
☐ Mosaicism-Specify_____
☐ High Resolution Banding
☐ Polymorphism Study
☐ FISH for X, Y, 13, 18 and 21
☐ Sub-Telomere Analysis
☐ Other FISH - Specify _____
☐ Fibroblast Only _____
☐ Chromosome Micro-Array CGH

HEMATOLOGY/ONCOLOGY CYTOGENETIC ANALYSIS

SPECIMEN TYPE

☐ Bone Marrow Aspirate Green Tube Rm. Temp (1 mL)

☐ Peripheral Blood Green Tube Rm. Temp (2-5 mL)

☐ Lymph Node Sterile Container/Media/Rm Temp

☐ Solid Tumor Sterile Container/Media/Rm Temp

Specify: _____

CLINICAL INFORMATIO (diagnosis under consideration)

_____

_____

TEST(S)

☐ Chromosome G-Banding Analysis

☐ FISH-specify_____

☐ Chromosome Micro-Array CGH

BONE MARROW TRANSPLANT

☐ Autologous ☐ Allogeneic ☐ Sex Mismatch

☐ Chromosome G-Banding Analysis
☐ FISH (X/Y centromere)
☐ FISH other - specify: _____

PATIENT CONSENT

I have read the information on the back of this form and discussed it with my health care provider. I have been given the opportunity to ask questions and have them answered about the tests ordered. I authorize collection and analysis of the necessary sample(s).

Patient/Legal Guardian: Date: Health Care Provider:

Important Information about Genetic Testing

1. This test will look for changes in the DNA chromosomes, genes, or gene products which are known to be associated with the specific genetic condition in question.

2. This test may reveal that the individual tested is affected with the condition, carries the genetic pre-disposition for it, or that he/she does not. If a positive result is obtained, a medical and/or genetic counseling follow-up may be advised.

3. Genetic testing is ordinarily highly accurate, however, in some cases results may not be obtained or may be inconclusive. Also, accurate genetic testing depends upon an accurate diagnosis in affected family members. If the diagnosis in a family is not certain, results can be misleading. I have been able to discuss the expected accuracy of the testing in my particular case. Initial: _____

4. Some genetic testing may require comparison of samples from multiple family members with their consent, and in these cases, previous unknown non-paternity can be discovered.

5. Some genetic tests are only done by a few laboratories in the world. This sample may need to be sent out of state to laboratories that are not certified by the New York State Health Department. In these cases, approval for testing will be obtained from New York State.

6. Some types of genetic testing such as fluorescence in situ hybridization (FISH) are considered investigational by the New York State Health Department. Using DNA probes which bind to specific regions of the chromosomes, FISH is helpful in identifying the origin of unidentified "marker" chromosomes, unusual variations in chromosome structure or small chromosomal deletions which cannot be seen by standard chromosome testing. FISH may be used, if indicated on my sample. Initial :_____

7. Chromosome microarray CGH (Array CGH) test is considered to be investigational by the New York State Department of Health. Array CGH is helpful in detecting gains or losses of chromosomal material at the DNA level anywhere in the genome. The method uses cloned DNA probes 'on a chip' to detect deletions or duplications which cannot be seen by standard chromosome and FISH analysis. The purpose of this assay is to detect syndromic microdeletions/duplications and subtelomeric alterations. Copy number alterations of single loci may be false negative due to the limited resolution of the array CGH. Because array CGH is a new technology being used in clinical diagnosis, all abnormal array CGH findings will be confirmed by standard chromosome or FISH analysis. Parental studies and additional assays may be necessary to characterize and interpret the clinical significance of array CGH results. The array CGH is limited to the detection of copy number changes in the genome. It will not detect balanced translocations, inversions, low level mosaicism, point mutations and genomic regions not represented on the array.

   Array CGH is used as an adjunct to chromosome analysis and all patients are required to have a chromosome analysis along with array CGH testing.

   The patient or their legal counsel is required to sign an informed consent befor the array CGH is performed. Due to the complexity of array CGH, the results will be reported directly to the ordering provider. Initial : _____

8. Records of this testing or test results will not be released to anyone other than me, my referring doctors and Strong Memorial Medical Records unless I specify otherwise. Initial: _____

9. No tests other than those authorized shall be performed on the biological sample and that the sample shall be destroyed at the end of the testing process or not more than sixty days after the sample was taken. Any part of the biological sample not used for specific genetic testing may be retained and used for medical research as long as names and other identifying information are not revealed. Initial : _____

10. I indicate my desire to opt out of participation in anonymized research studies using my DNA sample by checking this box: