



# Specimens:	Blue:	Lav:	Red:	SST:	Grn:	Gray:	Urine	Micro:
Collect Date:	Time:	By:	Depot:	ABN Signed: <input type="checkbox"/>				
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 _____

Practice Name _____

Address _____

Address2 _____

City, State, Zip _____

Phone# _____

Ordering Provider _____

Indicate primary (1) and secondary (2) insurance

Blue Cross/Shield Child Health Plus MVP

Blue Choice Medicaid MHPG

Medicare Blue Choice Medicare Aetna

Other _____

1. Primary Contract #: _____

Subscriber's Name: _____

Relationship to Subscriber: _____

2. Secondary Contract _____

Subscriber's Name: _____

Relationship to Subscriber: _____

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.

Microarray CGH

Prenatal/Pediatric Specimens

SPECIMEN TYPE

Amniotic Fluid - Call for Requirements (585) 275-1784

CVS - Call for Requirements (585) 275-1784

Date of Ultrasound ___/___/___ GA on Date of Ultrasound ___ weeks ___ days

Peripheral Blood (URMC) Lavender/Green Top/RmTemp (2-5 mL)

POC Sterile Container/Media/Refrig.

CYTOGENETICS

TEST(S) * Patient Consent required

(25789) Chromosome Analysis (Karyotype)

(16807) FISH N* (Specify _____)

RESTRICTED TEST
(REQUIRES AUTHORIZED PHYSICIAN'S SIGNATURE)

Abnormal Maternal Serum/First Trimester Screen - specify _____

Abnormal Ultrasound

Autism

Congenital Anomalies - specify: _____

Developmental Delay

Dysmorphic Features

Family History of Chromosome Abnormality - specify: _____

Failure to Thrive

History of SAB

Mental Retardation

Neurological disorders specify: _____

Seizures

Other - specify: _____

MICROARRAY CGH

TEST(S) * Patient Consent required

4 X 44K

4 X 180K + SNP

Parental FISH Confirmation*

Family h/o of affected, MRN# _____

PATIENT CONSENT

I have read the information on the consent 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: _____

Cytogen Sendout-1-2014

SEND ORIGINAL REQUISITION WITH SAMPLE

Microarray CGH Testing Patient Clinical Information Form

(page 2 of 4)

The accurate interpretation and reporting of genetic results is contingent upon the reason for referral, clinical information provided, and family history. To help provide the best possible service, please supply the information requested below and send paperwork with the specimen or return by fax to the Microarray Laboratory, Fax (585) 272-9166

Type of Sample: _____

Patient's Name: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: _____
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Clinical information - please check all that apply

<p><u>Perinatal History:</u></p> <p><input type="checkbox"/> Prematurity</p> <p><input type="checkbox"/> IUGR</p> <p><input type="checkbox"/> Oligohydramnios</p> <p><input type="checkbox"/> Polyhydramnios</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Growth:</u></p> <p><input type="checkbox"/> Failure to Thrive</p> <p><input type="checkbox"/> Overgrowth</p> <p><input type="checkbox"/> Short stature</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Development:</u></p> <p><input type="checkbox"/> Fine motor delay</p> <p><input type="checkbox"/> Gross motor delay</p> <p><input type="checkbox"/> Speech delay</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Cognitive:</u></p> <p><input type="checkbox"/> Learning disability</p> <p><input type="checkbox"/> Mental retardation List IQ/DQ, if known: _____</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Behavioral:</u></p> <p><input type="checkbox"/> Asperger syndrome features</p> <p><input type="checkbox"/> Autism</p> <p><input type="checkbox"/> Oppositional-defiant disorder</p> <p><input type="checkbox"/> Obsessive-compulsive disorder</p> <p><input type="checkbox"/> Pervasive developmental delay</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Other</u></p> <p><input type="checkbox"/> Other: _____</p>	<p><u>Neurological:</u></p> <p><input type="checkbox"/> Ataxia/dystonia/chorea</p> <p><input type="checkbox"/> Hypotonia</p> <p><input type="checkbox"/> Neural tube defect</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Spasticity</p> <p><input type="checkbox"/> Structural brain anomaly</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Cardiac:</u></p> <p><input type="checkbox"/> ASD</p> <p><input type="checkbox"/> AV canal defect</p> <p><input type="checkbox"/> Coarctation of aorta</p> <p><input type="checkbox"/> Hypoplastic left heart</p> <p><input type="checkbox"/> Tetralogy of Fallot</p> <p><input type="checkbox"/> VSD</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Craniofacial:</u></p> <p><input type="checkbox"/> Cleft lip +/- cleft palate</p> <p><input type="checkbox"/> Cleft palate alone</p> <p><input type="checkbox"/> Coloboma</p> <p><input type="checkbox"/> Craniosynostosis</p> <p><input type="checkbox"/> Dysmorphic facial features</p> <p><input type="checkbox"/> Ear malformation</p> <p><input type="checkbox"/> Macrocephaly</p> <p><input type="checkbox"/> Microcephaly</p> <p>List HC, if known: _____</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Cutaneous:</u></p> <p><input type="checkbox"/> Hyperpigmentation</p> <p><input type="checkbox"/> Hypopigmentation</p> <p><input type="checkbox"/> Other: _____</p>	<p><u>Musculoskeletal:</u></p> <p><input type="checkbox"/> Contractures</p> <p><input type="checkbox"/> Club foot</p> <p><input type="checkbox"/> Diaphragmatic hernia</p> <p><input type="checkbox"/> Limb anomaly</p> <p><input type="checkbox"/> Polydactyly</p> <p><input type="checkbox"/> Scoliosis</p> <p><input type="checkbox"/> Syndactyly</p> <p><input type="checkbox"/> Vertebral anomaly</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Gastrointestinal:</u></p> <p><input type="checkbox"/> Gastroschisis</p> <p><input type="checkbox"/> Hirschsprung disease</p> <p><input type="checkbox"/> Omphalocele</p> <p><input type="checkbox"/> Pyloric stenosis</p> <p><input type="checkbox"/> Tracheoesophageal fistula</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Genitourinary</u></p> <p><input type="checkbox"/> Ambiguous genitalia</p> <p><input type="checkbox"/> Hydronephrosis</p> <p><input type="checkbox"/> Hypospadias</p> <p><input type="checkbox"/> Kidney malformation</p> <p><input type="checkbox"/> Undescended testis</p> <p><input type="checkbox"/> Urethra/ureter obstruction</p> <p><input type="checkbox"/> Other: _____</p> <p><u>Family History:</u></p> <p><input type="checkbox"/> Parents with ≥ 2 miscarriages</p> <p><input type="checkbox"/> Other relatives with similar clinical history (please explain below)</p> <p><input type="checkbox"/> Parental Sample Proband _____</p>
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Clinical descriptions - please include any additional relevant clinical information not provided above:

Patient Name _____ Date of Birth _____

INFORMED CONSENT FOR GENETIC TESTING

1. Genetic testing will look for changes in the DNA, genes, or chromosomes which may be associated with a specific genetic condition. A positive test result is an indication that the individual may be predisposed to or have the specific disease or condition tested for and may wish to consider further independent testing. If a positive result is obtained, medical and/or genetic counseling follow-up may be advised.

2. As with any test, in some cases, results may not be obtained and a repeat sample may be requested or parental samples may be requested to further understand the findings. When parental testing is performed, it may show changes related to those found in the individual originally tested (usually a child or fetus). In those cases, this information regarding parental test results would become part of the child's (fetus's) test report. Thus it would appear the the child's(mother's) medical record.

3. Some types of genetic testing such as fluorescence in situ hybridization (FISH) are approved by the New York State Department of Health:

FISH, which uses DNA probes which bind to a specific region of a chromosome, is helpful in identifying "marker" chromosomes, variations in chromosome structure, or small deletions or duplications on a chromosome.

Microarray CGH analysis looks for extra or missing pieces of DNA that are too small to been seen by standard chromosome testing. It uses tiny "DNA probes" to look for thousands of possible changes at the same time. Many results will be negative, but some will find changes that are: (1) associated with known genetic syndromes, (2) not well understood, or (3) "normal variations" in the general population. Because certain types of chromosome changes (translocations, inversions, low leel mosaicism, etc.) cannot be detected by array CGH, testing is often performed with standard chromosome analysis.

4. FOR URMIC PROVIDERS ONLY: Some genetic tests are performed at only a few laboratories; therefore, the sample may need to be sent to a laboratory that is not certified by the New York State Health Department. In these cases, approval for testing will be obtained from New York State.

5. No tests other than those authorized by the patient (or guardian) will be performed on the sample and the sample will be destroyed when testing is complete or not more than sixty days after the sample was taken, unless permission is granted in Section 8 to retain the sample for research.

6. The patient may wish to obtain professional genetic counseling priot to signing this consent.

7. Test results will not be released to anyone other than the referring doctor(s) and the University of Rochester Medical Center Medical Records.

8. The Microarray CGH Laboratory retains patient samples indefinitely for validation, educational purposes, and/or research. The submitted clinical information and test results are also included in a HIPAA-compliant, de-identified public database as part of the National Institute of Health's effort to improve diagnostic testing and the understanding of the relationship between genetic changes and clinical symptoms (for information about the database, visit www.iscaconsortium.org). Confidentiality of each sample is maintained. patients may request to withdraw consent for storage of their sample and/or use of teh data by: (1) initialing the statement below or (2) calling the laboratory at 585-350-2600 and asking to speak to a Microarray CGH technologist.

_____ YES, this sample may be kept as long as the names and other identifying information are removed

_____ NO, this sample may not be kept and myst be discarded at the end of the testing process.

The patient (or legal counsel) is required to sign the consent prior to genetic testing being performed.

Therefore, please sign this form at the bottom of page 1.

Microarray (page 4 of 4)

Patient Name _____

Date of birth _____

Chromosomal Microarray Testing and the ISCA Consortium Database

Your doctor has ordered chromosomal microarray as part of your or your child's medical evaluation. This test is used to look for a genetic cause of problems in the physical, intellectual and behavioral development of children and adults. The chromosomal microarray has significantly improved our ability to find the underlying cause of many developmental and medical concerns, allowing families to learn about specific result and make informed plans for medical and/or educational interventions.

The chromosomal microarray is away for the laboratory to look at the entire genetic make-up of a person in order to find missing (loss) or extra (gain) pieces of the chromosomes. Many of the losses and gains found by microarray are common and have a well understood pattern of medical problems, However, some microarray results are rare and have not been seen before. In some cases, it is not a problem or not, or what medical problems may be expected. Parental testing can sometimes help to clarify this type of uncertain result.

More information is needed to understand rare results and you can help!

Your or your child's sample is being sent to URM's Microarray CGH lab for microarray testing. URM_Labs is a member of the International Standard Cytogenomic Array (ISCA) Consortium, an organization of more than 85 laboratories working together to gather the information needed to understand the meaning of rare chromosomal microarray results. For each order received for microarray testing, URM_Labs contributes the microarray result along with the reason for testing (such as autism or heart defect) to the central ISCA Consortium database.

Privacy is of the utmost importance to us, therefore all patients identity information is removed (de-identified) before results are submitted. Your confidentiality is maintained.

The ISCA Consortium database is only possible through the contribution of individual patient results. With your help, as the ISCA database grows over time, laboratories will be able to use the information to improve the reporting of rare results. Patients with an uncertain result may then learn the true meaning of their microarray result and optimize their medical care.

To Opt-Out of the ISCA Database

There are three ways to opt-out:

1. Check the opt-out box on page 3 section 8 of test requisition form.
2. Calling client services at 1-800-747-4769 option 3
3. Calling the Microarray CGH Laboratory at 585-350-2650

Please call either client services or the Microarray CGH Laboratory at the numbers above if you have questions about the use of your information or sample.