UR MEDICINE | Labs

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

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 | Chart 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:

Doctor: _____

Address: _____

_____

_____

Phone Results to: Fax Results to:

Ordering Provider's Signature

Date of Signature

Diagnosis Mandatory: Signs/Symptoms or ICD10 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-10 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 (Do not Add Formalin) 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

☐ FISH for X, Y, 13, 18 and 21

☐ Other FISH - Specify _____

☐ Fibroblast Only _____

Chromosome Micro-Array CGH

☐ 4 X 44K

☐ 4 X 180K + SNP

☐ Parental FISH Testing (FISHP)

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: _____

☐ Urine/Bladder Wash Sterile Container/Refrig

CLINICAL INFORMATION (diagnosis under consideration)

_____

_____

_____

_____

_____

TEST(S)

☐ Chromosome G-Banding Analysis

☐ FISH-specify_____

☐ Chromosome Micro-Array CGH (4X 180K + SNP)

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:

HEALTHCARE PROVIDER CONSENT

I attest that I have reviewed the requirements for genetic testing order on the requisition with the patient. I have conveyed the required information to the patient and obtained consent.

Health Care Provider: Date:

UR Medicine Labs Cytogenetics Laboratory

601 Elmwood Ave
Rochester, New York 14642
Phone:(585)275-5859
FAX: (585)276-2380

Informed Consent for Cytogenetic Testing

Patient Name_____ Date of Birth__/__/_____ Gender __Female __Male

Test Indication_____

Sample Type: __Blood __Bone Marrow __Tissue (Specify)_____ __Cord Blood __ Amniotic Fluid __Chorionic Villi

Test(s) Name(s) to be performed

□ Chromosome Analysis □ FISH- Probe/Panel:_____ □ Chromosomal Microarray

For more information on FISH testing and probes ordered please visit our website:
https://www.testmenu.com/rochester/Tests/68252

For more information on Chromosome Microarray testing:
https://www.urmc.rochester.edu/pathologylabs/clinical/microarray.aspx

I request and authorize URMC Labs to perform only the above designated test(s) on the sample from me (or my child or fetus). The signature below constitutes my acknowledgment that the benefits, risks and the limitations of this testing have been explained to my satisfaction by a qualified health care professional. Because of the complexity of genetic testing and the important implications of the test results, results will be reported only through a physician, genetic counselor or other identified health care provider. In addition, to fully understand what the risks and benefits are to having the genetic testing, professional genetic counseling is advised prior to giving consent and upon receipt of results genetic counseling may be advised and is available.

The following has been explained to me:

1. Cytogenetic testing may:
    a. Identify whether there is extra, missing or rearranged genetic material
    b. Diagnose whether or not I have (or my child or fetus has) a particular condition or am at risk for developing this condition.
    c. Identify a chromosomal condition that I did not know I (or my child or fetus) was at risk for
    d. Identify whether or not I (or my child or fetus) am a carrier for this condition
    e. Predict another family member has or is at risk for the condition
    f. Be indeterminate due to technical limitations

2. A positive result is an indication that I (or my child or fetus) may be predisposed to or have the specific disease or condition. Further independent testing may be needed to confirm the diagnosis.

3. There is a chance that I will have a chromosomal condition but the cytogenetic test results will be negative due to the limitations of this technology.

4. Cytogenetic testing results are not intended to be used as the sole means for clinical diagnosis or patient management decisions.

5. Cytogenetic test results are confidential and are released to the ordering health care provider and those parties entitled to them by state and local law.

6. Incidental findings (findings unrelated to the reason for referral) may be discovered. These findings will be reported to the provider for clinical determination.

7. My (or my child's or my fetus') sample may be used for test validation, education, or research after my personal identifiers are removed. Initials:_____ Yes _____No If not specified, yes will be considered the default.

8. All samples will be disposed of 60 days after testing is complete per NYS Civil Rights Law section 79-L unless consent is given for validation, education or research use.