



# 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	Chart Number

Phone Results to:	Fax Results to:
Ordering Provider's Signature	Date of Signature
Diagnosis Mandatory: Signs/Symptoms or ICD10 Codes <i>If ordered for screening, list test name here and write "SCREENING" after it</i>	
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.	

**CONSTITUTIONAL STUDIES \*INFORMED CONSENT REQUIRED****SPECIMEN TYPE**

- Amniotic Fluid       CVS Gestational Age: \_\_\_\_\_ Sterile container, transport room temp, transport media upon request.
- Peripheral Blood      Green top sodium heparin, transport room temp.
- Tissue (specify): \_\_\_\_\_ Sterile container, media/sterile saline, transport room temp, transport media upon request.
- POC (Do not add Formalin)      Sterile container, media/sterile saline, transport room temp, transport media upon request.
- Other (specify): \_\_\_\_\_

**TEST(S) \*Patient Consent Required**

- Chromosome Analysis
- FISH (AneuVysion) (13, 18, 21, X, Y)
- FISH Other (specify): \_\_\_\_\_
- MicroArray       FISHP: \_\_\_\_\_
- Culture Only
- Send Out (specify): \_\_\_\_\_

**INDICATION(S) FOR TEST**

- Abnormal Ultrasound
- Advanced Maternal Age
- Abnormal Screen (specify): \_\_\_\_\_
- History of SAB
- Family History Chromosome Abnormality (specify): \_\_\_\_\_
- 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: \_\_\_\_\_

**HEMATOLOGY/ONCOLOGY CYTOGENETIC ANALYSIS****SPECIMEN TYPE**

- Bone Marrow      Green top sodium heparin, transport at room temp.
- Peripheral Blood      Green top sodium heparin, transport at room temp.
- Bladder Wash      Sterile Container/Ship on Ice, Cold Paks/Refrig.
- Urine      Sterile Container/Ship on Ice, Cold Paks/Refrig.
- Flow: \_\_\_\_\_
- FFPE: Block \_\_\_\_\_
- Tissue (specify): \_\_\_\_\_
- Other (specify): \_\_\_\_\_

**INDICATION(S) FOR TEST**

- Diagnosis (specify): \_\_\_\_\_
- Post ALLO BMT       Male Donor       Female Donor
- Hematuria
- History Bladder Cancer
- Other: \_\_\_\_\_

**TEST(S)**

- Chromosome Analysis
- FISH (specify probes): \_\_\_\_\_
- FISH (UroVysion)
- Send Out (specify): \_\_\_\_\_

### Informed Consent for Cytogenetic Testing

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_ Sex: Female \_\_\_ Male \_\_\_

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/pathology-labs/clinical/healthcare-providers/consent-forms.aspx>

I request and authorize URM 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, no 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.