Integrated GENETICS
LabCorp Specialty Testing Group

PRENATAL CYTOGENETICS/FISH/MICROARRAY TEST REQUISITION

Highlighted fields are required.

Patient Information

Name
Last First MI

☐ Male ☐ Female Date of Birth / /

Address

Home Phone Work Phone

City State Zip

Lab # Hospital #

Client Information

I have obtained informed consent of the patient (or the patient's authorized representative) for the ordered genetic test(s) in accordance with applicable law.

Physician/Authorized Signature:

NPI#: Taxonomy#:

Referring Physician (print):

Genetic Counselor (print):

Refer to www.integratedgenetics.com to access informed consent forms for genetic testing.

Date collected: / / Date sent: / / Collected by:

Pregnancy: ☐ Yes ☐ No

Date of ultrasound: / / GA on date of US: weeks days

Sex of the fetus if known: Date of LMP: / / GA by LMP: weeks days

Gestation History

of Fetuses: ☐ 1 ☐ 2 ☐ >2 (submit separate requisitions)

Gravida _____ Para _____ SAB _____ TAB _____

Specimen Type: (check one)

☐ **Amniotic Fluid** ☐ **CVS** ☐ **PUBS** ☐ **Other** _____

☐ **Parental blood for** _____

Hold cells for _____

☐ **POC/Fetal Tissue** (weeks gestation_____ tissue origin _____)

☐ **Cultured amniocytes/CVS/POC (circle one)**

Laboratory Test(s) Ordered (*Reflex Policy on back)

See back ☐ Chromosome analysis

477 ☐ If chromosomes are normal, reflex to Reveal® SNP Microarray – Prenatal*

478 ☐ If POC/tissue fails to grow, reflex to Reveal® SNP Microarray – POC*

477 ☐ Reveal® SNP Microarray – Prenatal ☐ Direct on amnio or CVS

☐ MCC analysis specifically with Reveal® SNP Microarray

478 ☐ Reveal® SNP Microarray – POC ☐ Direct on POC

See back ☐ Reveal® SNP Microarray & Abbreviated Chromosome Analysis

451890 ☐ Noonan syndrome – prenatal

300 ☐ AF-AFP (alphafetoprotein)*

330 ☐ AChE (acetylcholinesterase)*

105 ☐ InSight® (FISH for 13, 18, 21, X and Y)

287 ☐ DiGeorge/VCF (FISH)

☐ Other FISH test – specify _____

☐ Parental follow-up to Reveal® SNP Microarray (additional charges may apply)
Test code on original report: _____
(Attach a copy of the original report or the name of the patient previously tested)

☐ **Other Testing – specify (call before sending)** _____

_____

_____

_____

All diagnoses should be provided by the ordering physician or an authorized designee.
Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required)

ICD-CM		ICD-CM		ICD-CM	

Indication(s) for Test (check all that apply)

If ordering Reveal® SNP Microarray please submit Clinical Questionnaire

☐ Advanced maternal age (≥35) ☐ gravida 1 ☐ gravida 2+

☐ Abnormal maternal serum/first trimester screen. Increased risk of:

☐ NTD ☐ Down Syndrome ☐ Trisomy 18

☐ Other (specify): _____

☐ Abnormal fetal ultrasound:

☐ CNS _____

☐ Heart _____

☐ Genitourinary _____

☐ Growth/skeletal _____

☐ Oligohydramnios/polyhydramnios _____

☐ Other _____

☐ Multiple SABs (Spontaneous abortion): ☐ Pregnant ☐ Not Pregnant

☐ Fetal loss/Stillbirth (POC) ☐ <20 wks ☐ >20 wks

☐ Parental chromosome analysis following abnormal prenatal results
Specify _____

☐ Confirm prenatal analysis

☐ Clarify abnormal fetal chromosomes - provide results and a copy of the karyotype

☐ Other _____

Family History

☐ Family history of chromosome abnormality
Specify/include copy of report: _____
Specify relationship of affected individual: _____

☐ Family history of other genetic disorder
(Specify relationship of affected individual):

☐ Birth defects (specify) _____

☐ ID/DD _____

☐ Autism/Autism spectrum disorders _____

☐ Parent(s) carrier(s) of _____

☐ Parent has chromosome rearrangement/mosaicism _____

☐ Fetus at risk for _____

☐ Other _____

BILLING INFORMATION

Patient Hospital Status: ☐ Inpatient ☐ Outpatient ☐ Non-hospital

☐ Medicaid ☐ Medicare ☐ Insurance ☐ Client Bill ☐ CA XAFP ☐ Self-Pay

☐ Billing Information Attached (Please include a copy of insurance card or face sheet.)

Do not attach credit card information to this form for security purposes.

Insurance Company Name _____

Policy # _____ Group # _____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Patient Signature _____ Date: _____

INTEGRATED GENETICS INTERNAL USE ONLY

By signing this form, I hereby authorize Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to LCAH.

I understand that I am responsible for any amounts not paid by insurance for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.

Bill Codes:	Chromosome Analysis	Abbreviated Chromosome Analysis	Reveal® SNP Microarray
	100 Amniotic Fluid	101 Amniotic Fluid	477 Prenatal
	110 CVS	111 CVS	478 POC
	123 PUBS	124 PUBS	
	180 POC/Fetal Tissue	181 POC/Fetal Tissue	

*REFLEX POLICY: The following will be performed by reflex at an additional charge. **AChE** when AF-AFP is elevated &/or gestational age is out of range of normative values. **Fetal Hemoglobin** when AF-AFP is elevated and amniotic fluid is bloody. **Microarray** testing when chromosomes are normal or POC/tissue fails to grow and reflex is requested.

B1A