CONSTITUTIONAL (BLOOD) TEST REQUISITION FORM

Cytogenetic Laboratories
Indiana University School of Medicine
635 Barnhill Dr. MS 350, Indianapolis, IN 46202
317/274-2243 (Office) 317/278-1616 (Fax)
317/274-1053 or 317/274-2246 (Lab)

Patient Laboratory Label

CAP#: 16789-30 CLIA#: 15D0647198

1) PHYSICIAN(S):

Ordering Signature:_____

Ordering Physician:_____
Address:_____
City: _____ State: _____ Zip: _____
Phone:_____ Fax:_____

Primary Physician:_____
Address:_____
City: _____ State: _____ Zip: _____
Phone:_____ Fax:_____

FOR LABORATORY USE ONLY:

Date Received: _____/_____/_____ Family #: _____
Time Received: _____:_____am/pm Proband: ☐ Not Proband: ☐
Received By: _____

☐ BL ☐ FISH x _____ Probes ☐ FISH **ONLY**

☐ CMA ☐ MO ☐ C-banding ☐ Q-banding ☐ NOR-staining

Handling Charge x _____ ☐ Handling **ONLY**

Lab Comment(s): Vacs: _____ green _____ purple; Other _____

2) PATIENT INFORMATION:

Patient Name: _____
Last Name *First Name* *Middle Initial*

Address: _____
Street *City* *State* *Zip Code*

Hospital: _____ Medical Record #: _____

Date of Birth: _____/_____/_____ Patient's Sex: ☐ Male ☐ Female Patient Recently Pregnant: ☐ Yes ☐ No
Month *Day* *Year*

3) CLINICAL INFORMATION:

Collection Date: _____/_____/_____ Collection Time:_____:_____am/pm Collected By: _____
Month *Day* *Year*

☐ Blood
☐ Cord Blood

Recently transfused: ☐ Yes ☐ No Date: _____

4) REFERRING DIAGNOSES *(please check all that apply)*:

☐ Ambiguous Genitalia
☐ Autism Spectrum Disorder
☐ Congenital Heart Defect
☐ Developmental Delay
☐ Down Syndrome
☐ Dysmorphic Features
☐ Failure to Thrive
☐ Hypotonia
☐ Multiple Congenital Anomalies
☐ Recurrent Pregnancy Loss
☐ Seizures
☐ Short Stature
☐ Other _____
☐ ICD-10 Code: _____
☐ Family History of Chromosome Abnormality **(Please provide name, DOB, MRN)** _____

5) REQUESTED TESTING:

☐ Standard Chromosome Analysis/Karyotype:
-- 1 Sodium Heparin Tube (Dark Green-top); 3 mL (infants), 7 mL (adults)

☐ Rapid Chromosome Analysis/Karyotype:
-- Preliminary result in 48-72 hours
-- 1 Sodium Heparin Tube (Dark Green-top); 3 mL (infants)

☐ Constitutional Chromosomal Microarray Analysis (CMA):
-- Requires two tubes of blood:
1 EDTA Tube (Purple-top); minimum 3 mL
1 Sodium Heparin Tube (Dark Green-top); minimum 3 mL

☐ Peripheral Blood for Fanconi Anemia Breakage Study using DEB:
-- 2 Sodium Heparin Tubes (Dark Green-top); 7-12 mL

☐ Fluorescence In Situ (FISH) Analysis *(Select Probe below)*
-- 1 Sodium Heparin Tube (Dark Green-top); 2 mL

☐ Standard Chromosome Analysis **with** Reflex to Microarray (CMA):
-- Reflexes if karyotype is normal.
-- Requires two tubes of blood:
1 EDTA Tube (Purple-top); minimum 3 mL
1 Sodium Heparin Tube (Dark Green-top); 3 mL (infants), 7 mL (adults)

☐ Standard Chromosome Analysis **and** Microarray (CMA) Analysis:
-- Simultaneous testing for both karyotype and CMA analysis.
-- Requires two tubes of blood:
1 EDTA Tube (Purple-top); minimum 3 mL
1 Sodium Heparin Tube (Dark Green-top); 3 mL (infants), 7 mL (adults)

☐ Parent/Family Member CMA FISH Confirmation Analysis:
-- For parent/family member of patient w/ abnormal CMA Results confirmed by FISH testing. Please provide previous patient information (Name, MRN, DOB)
-- 1 Sodium Heparin Tube (Dark Green-top); 2mL

6) MICRODELETION FISH ANALYSIS REQUESTED:

☐ Angelman
☐ Cri-Du Chat
☐ DiGeorge (VCFS)
☐ Kallman
☐ Miller-Dieker
☐ Prader-Willi
☐ Smith-Magenis
☐ SRY
☐ STS
☐ Subtelomere by CMA
☐ Williams
☐ Wolf-Hirschhorn

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7) PATIENT FINANCIAL AUTHORIZATION/INSURANCE BENEFIT VERIFICATION:

IMPORTANT: Patient and health care providers desiring private insurance billing MUST complete and submit the signed Patient Financial Authorization/Insurance Benefit Verification portion prior to or at the time of sample submission. *Failure to do so will delay testing/results*.

Patient Financial Authorization (Authorization To Assign Benefits And Financial Responsibility For My Account)

I assign and authorize insurance payments to Indiana University Medical Genetics Services Inc. I understand my insurance carrier may not approve and reimburse my medical genetic services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, or medical necessity or otherwise. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles (not to exceed $5,000) except where my liability is limited by contract or State and Federal law. A duplicate or faxed copy of this authorization is considered the same as the original document.

Signature of Patient or Guardian Printed Name of Patient for Guardian Date

Patient Authorization for Insurance Benefit Verification

If the prior-authorization has been completed by the health care provider, please provide the information below to proceed with testing.
Prior-Authorization Number:

Authorization To Contact Health Insurance Carrier And Release Confidential Medical Information

I understand Indiana University Medical Genetics Services Inc. may contact my insurance carrier regarding coverage of genetic testing. I authorize the disclosure of insurance benefit coverage and payment information to Indiana University Medical Genetics Services Inc. I authorized my physician or other medical entity to release confidential medical information to I.U. Genetic Testing Laboratories concerning my medical history. I authorize Indiana University Medical Genetics Services Inc. to release confidential medical information to my health insurance carrier to facilitate reimbursement of my medical fees.

Signature of Patient or Guardian Printed Name of Patient for Guardian Date

Health Care Providers Please Provide the Following:

1. Patient Demographic Sheet
2. Enlarged Copy of Insurance Card/s (Front and Back)
3. Patient's Insurance: Policy/Identification #: _____ Group #: _____
   Insurance/Managed Care plan: _____
   Street Address: _____ City: _____ State: _____ Zip: _____
   Insurance Phone Number: _____ Insurance FAX Number: _____
   Relationship to Insured: ☐ Self ☐ Spouse ☐ Other: _____
4. Please Indicate the Following: ☐ Bill Patient/Self Pay (*Demographic Sheet Required*) ☐ Bill Hospital
5. The Above Portion Signed by the Patient/Guardian
6. The Diagnosis and ICD-9 Codes: _____

8) SPECIMEN COLLECTION REQUIREMENTS

Specimen	Collection	Container(s)	Instructions
Peripheral Blood for Chromosome Analysis	7-10 mL whole blood (adults) 2-4 mL whole blood (infants)	Dark Green-top, Sodium Heparin vacutainer tube.	**Keep at room temperature.** If post-mortem, obtain by cardiac puncture within 1 hour.
Peripheral Blood for Microarray (CMA)	3-5 mL whole blood (per tube)	1 Purple-top, EDTA vacutainer tube **AND** 1 Dark Green-top, Sodium Heparin vacutainer tube.	**Keep at room temperature.**
Peripheral Blood for Fanconi Anemia Testing	7-12 mL whole blood	Dark Green-top, Sodium Heparin vacutainer tube.	**Keep at room temperature.**
Cord Blood for Chromosome Analysis	2-4 mL	Dark Green-top, Sodium heparin vacutainer tube.	**Keep at room temperature.**

9) SPECIMEN HANDLING REQUIREMENTS

- Use sterile technique; close all containers tightly.
- **Do not freeze any specimen type.**
- Label all containers and requisition forms with patient name, MRN, date of collection, and physician name.
- **Specimens should be received within 24 hours of collection.**