

### CYTOGENETICS TEST REQUISITION

#### SHIP TO: MEDICAL GENETICS LABORATORIES

Baylor College of Medicine  
2450 Holcombe, Grand Blvd. - Receiving Dock  
Houston, TX 77021-2024

#### !STOP IMPORTANT BILLING INFORMATION!

Indicate Institution Billing Code here: \_\_\_\_\_, OR  
complete and fax billing information form (page 2 of requisition)  
to 713-798-4187. **Samples received without the Institution  
Code or Billing Form cannot be processed.**

FOR PRENATALS, PLEASE USE PRENATAL REQUISITION FORM.

#### REPORTING INFORMATION

PHYSICIAN/INSTITUTION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

PHONE #: (\_\_\_\_) \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_

Additional Reports to:

1. NAME: \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_

2. NAME: \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_

#### PATIENT DATA

NAME (Last, First, Middle Initial): \_\_\_\_\_

DATE OF BIRTH (MM/DD/YY): \_\_\_\_/\_\_\_\_/\_\_\_\_

Please check one:  MALE  FEMALE  UNKNOWN

HOSPITAL #: \_\_\_\_\_

ACCESSION #: \_\_\_\_\_

KCL #: \_\_\_\_\_

MEDICAL RECORD #: \_\_\_\_\_

#### SAMPLE INFORMATION

DATE SAMPLE OBTAINED (MM/DD/YY): \_\_\_\_/\_\_\_\_/\_\_\_\_ TIME SAMPLE OBTAINED: \_\_\_\_\_

SAMPLE TYPE:  BLOOD  TISSUE  OTHER: \_\_\_\_\_

TISSUE BIOPSY LOCATION:  SKIN  PLACENTA  CORD  PRODUCTS OF CONCEPTION (POC)  OTHER: \_\_\_\_\_

IF PLACENTA OR POC, GESTATIONAL AGE: \_\_\_\_\_

#### INDICATION FOR STUDY

**MUST check one or more below and be completed thoroughly to avoid delay in sample processing.**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Ambiguous Genitalia  | <input type="checkbox"/> Infertility                   | <input type="checkbox"/> Trisomy 18                             |
| <input type="checkbox"/> Autistic Spectrum  | <input type="checkbox"/> Klinefelter Syndrome          | <input type="checkbox"/> Trisomy 21                             |
| Developmental Delay/Mental Retardation  | <input type="checkbox"/> Multiple Congenital Anomalies | <input type="checkbox"/> Turner Syndrome                        |
| <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | <input type="checkbox"/> Multiple Miscarriages (x____) | <input type="checkbox"/> Other: _____                           |
| <input type="checkbox"/> Dysmorphic Features  | <input type="checkbox"/> Seizure Disorder              | <input type="checkbox"/> FMHX of Chromosomal Abnormality: _____ |
| <input type="checkbox"/> Failure to Thrive  | <input type="checkbox"/> Testicular Failure            |   |
| <input type="checkbox"/> Fetal Demise   | <input type="checkbox"/> Trisomy 13                    |   |

Previous Cytogenetic Results (if applicable): \_\_\_\_\_

Performed Where: \_\_\_\_\_

Family Members Studied By This Laboratory: \_\_\_\_\_ KCL #: \_\_\_\_\_

#### TEST REQUESTED (Check all appropriate boxes)

- 8600  Chromosome Analysis
- 8635  44K Chromosomal Microarray Analysis - order through Athena Diagnostics: 1-800-394-4493 Ext. 2
- 8655  105K Chromosomal Microarray Analysis - order through Athena Diagnostics: 1-800-394-4493 Ext. 2
- Parental Studies (requested in CMA report) - **Required:** Proband Name or KCL#: \_\_\_\_\_ Attach copy of the report

#### Available FISH Studies:

- |  |  |
|--|--|
| 8457 <input type="checkbox"/> Adrenal Hypoplasia Congenita                             | 8473 <input type="checkbox"/> Multiple Exostoses (EXT2, Potocki/Shaffer)         |
| 8458 <input type="checkbox"/> Alagille Syndrome  | 8474 <input type="checkbox"/> Neurofibromatosis                                  |
| 8459 <input type="checkbox"/> Angelman Syndrome  | 8456 <input type="checkbox"/> 1p36 Deletion                                      |
| 8460 <input type="checkbox"/> Beckwith-Wiedemann Syndrome                              | 8475 <input type="checkbox"/> Pelizaeus-Merzbacher Disease(s)                    |
| 8462 <input type="checkbox"/> Charcot-Marie-Tooth (CMT1A)                              | 8476 <input type="checkbox"/> Prader-Willi Syndrome                              |
| 8464 <input type="checkbox"/> Cri-du-Chat Syndrome (5p-)                               | 8477 <input type="checkbox"/> Rubinstein-Taybi Syndrome                          |
| 8440 <input type="checkbox"/> DiGeorge Syndrome Panel (VCFS) (22q+10p)                 | 8478 <input type="checkbox"/> Smith-Magenis Syndrome                             |
| 8486 <input type="checkbox"/> DiGeorge Syndrome I (22q only)                           | 8479 <input type="checkbox"/> SOTOS Syndrome                                     |
| 8465 <input type="checkbox"/> DiGeorge Syndrome II (10p only)                          | 8480 <input type="checkbox"/> SRY Analysis                                       |
| 8466 <input type="checkbox"/> Glycerol Kinase Deficiency                               | 8481 <input type="checkbox"/> Telomeres Panel                                    |
| 8467 <input type="checkbox"/> Hereditary Neuropathy with Liability to Pressure Palsies | 8482 <input type="checkbox"/> Trichorhinophalangeal Syndrome (TRPS1)             |
| 8468 <input type="checkbox"/> Isolated Lissencephaly                                   | 8450 <input type="checkbox"/> WAGR Syndrome                                      |
| 8469 <input type="checkbox"/> Kallman Syndrome   | 8483 <input type="checkbox"/> Williams Syndrome                                  |
| 8430 <input type="checkbox"/> Langer Giedion (EXT1/TRPS1) Panel                        | 8455 <input type="checkbox"/> Wilms Tumor  |
| 8470 <input type="checkbox"/> Microphthalmia with Linear Skin Lesions (MLS/MIDAS)      | 8484 <input type="checkbox"/> Wolf-Hirschhorn Syndrome (4p-)                     |
| 8471 <input type="checkbox"/> Miller-Dieker Syndrome                                   | 8485 <input type="checkbox"/> X-linked Ichthyosis (Steroid Sulfatase Deficiency) |
| 8435 <input type="checkbox"/> Multiple Exostoses (EXT1/EXT2) Panel                     | <input type="checkbox"/> Other (Please Specify): _____                           |
| 8472 <input type="checkbox"/> Multiple Exostoses (EXT1)                                |  |

**BILLING INFORMATION FORM**

**STOP! ONE OF THE THREE FOLLOWING BILLING OPTIONS MUST BE INDICATED BELOW.**

The Self-Pay option must include payment with sample. We require and provide insurance pre-verification service. Please fax the *Patient Insurance Verification Form* (available at www.bcmgeneticlabs.org) to 713-798-4187. If the Billing Information section is incomplete, the referring physician, hospital, or laboratory will automatically be billed, or sample processing suspended. Please forward billing questions to: medgenbilling@bcm.edu

**PATIENT INFORMATION:**

Name (Last, First, Middle Initial): \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone #: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

**PAYMENT OPTIONS:**

1.  **Institution or referring MD Code (as assigned by BCM):** \_\_\_\_\_  
(or) Institution Name: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Financial Contact: \_\_\_\_\_  
E-mail (required): \_\_\_\_\_  
Phone #: (\_\_\_\_) \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_

2.  **Self-Pay: Check, Money Order, or Credit Card payment must accompany sample.**  
Credit Card (Please check one):  AMEX  Discover  MC  VISA  
Valid Card #: \_\_\_\_\_ Exp date (mm/yy): \_\_\_\_/\_\_\_\_ **CVC Code:** \_\_\_\_\_  
Cardholder printed name: \_\_\_\_\_  
Cardholder signature: \_\_\_\_\_

3.  **Insurance:** Please refer to the Financial Policy at <http://www.bcm.edu/geneticlabs/billing.html> for complete insurance filing information and managed care contract list. Insurance is filed to our contracted carriers as a courtesy. Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. HMO policies must have required authorizations. We do not file out-of-state Medicaid. Prenatal CMA requires a prepayment amount. Contact medgenbilling@bcm.edu with questions.

ICD9 Diagnosis Code(s) must be provided or insurance cannot be filed: **ICD-9 CODE:** \_\_\_\_\_  
 PPO, Commercial Insurance-provide Patient Insurance Verification form (PIVF) and front/back copy of card  
 HMO-provide PIVF, authorization, front/back copy of insurance card  
 Texas Medicaid/Texas Medicaid HMO-provide PIVF, authorization, front/back copy of Medicaid card

**Insured Policyholder's Information:**

Name: \_\_\_\_\_ Date Of Birth (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Insured SS or ID #:** \_\_\_\_\_ Gender (Please check one):  M  F  
Authorization: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Insurance Name: \_\_\_\_\_  
Employer: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
Insurance City, State, Zip: \_\_\_\_\_  
Insurance Phone #: (\_\_\_\_) \_\_\_\_\_

I authorize BCM Medical Genetics Laboratories to furnish any medical information requested on myself, or my covered dependents. In consideration of services rendered, I transfer and assign any benefits of insurance to BCM Medical Genetics Laboratories. I understand I am responsible for any co-pay, deductible, or non-covered service amounts. I understand I am fully responsible for payment of my account if the BCM Medical Genetics Laboratories is not a participant with my health plan, and my health plan does not fully reimburse my medical services due to lack of authorization or medical necessity.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_