

**PRENATAL TEST REQUISITION**

**PATIENT DATA**

NAME: \_\_\_\_\_

Last First Middle Initial

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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

**SHIP TO: MEDICAL GENETICS LABORATORIES**  
Baylor College of Medicine  
2450 Holcombe, Grand Blvd. - Receiving Dock  
Houston, TX 77021-2024

**REPORTING INFORMATION:**

PHYSICIAN CONTACT: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_

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

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

CITY, STATE, ZIP: \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_

Additional Reports to: 1. NAME: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_

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

**SAMPLE INFORMATION**

**CLINICAL:**

Date of Procedure: \_\_\_\_\_

Performing Physician: \_\_\_\_\_

GA at Procedure: \_\_\_\_\_  By LMP  By US

**INDICATION:**

- AMA
- Abnl Serum Screen:  NTD  Tri 21  Tri 18  
 Other: \_\_\_\_\_
- Abnl US - specify: \_\_\_\_\_
- Multiple Ab
- Parental Concern
- Other Indication (Detail and attach reports):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SPECIMEN TYPE**

- Amniotic Fluid \_\_\_\_\_cc
- Cultured Amniocytes
- CVS \_\_\_\_\_mg  TA  TC
- Cultured CVS
- Fetal Blood \_\_\_\_\_cc
- POC/Fetal Tissue  
Tissue Type: \_\_\_\_\_
- Parental Control Specimen
- Maternal Blood  Paternal Blood  
Name: \_\_\_\_\_  
DOB (MM/DD/YY): \_\_\_\_/\_\_\_\_/\_\_\_\_

**TEST REQUESTED**

**Notice:** Prior to ordering any of the disorder tests below, you must call the lab and discuss the clinical history and sample requirements with a genetic counselor.

**AVAILABLE CYTOGENETIC TESTING:**  Chromosome Analysis  AFAPP  AchE  Aneuploidy FISH (24-48 hrs for 13, 18, 21, X and Y)\*

**For Prenatal CMA, use separate requisition**

**Please call to confirm. Sequencing tests are available for Known Familial Mutations only.**

**AVAILABLE DISORDER TESTING:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Adenosine Deaminase Deficiency                                | <input type="checkbox"/> Diamond-Blackfan Anemia <i>RPS19</i>                            | <input type="checkbox"/> Osteogenesis Imperfecta, AR <i>CRTAP</i>               |
| <input type="checkbox"/> ad-PEO 2 <i>ANT1/SLC25A4</i>                                  | <input type="checkbox"/> DMD/BMD <i>Dystrophin</i>                                       | <input type="checkbox"/> Osteogenesis Imperfecta, AR <i>LEPRE1</i>              |
| <input type="checkbox"/> ad-PEO 3 <i>TWINKLE/PEO1</i>                                  | <input type="checkbox"/> Fabry Disease <i>GLA</i>  | <input type="checkbox"/> Ornithine Transcarbamylase (OTC) Deficiency <i>OTC</i> |
| <input type="checkbox"/> Angelman Syndrome <i>UBE3A</i>                                | <input type="checkbox"/> Familial Adenomatous Polyposis <i>APC</i>                       | <input type="checkbox"/> Pelizaeus-Merzbacher <i>PLP1</i>                       |
| <input type="checkbox"/> APECED <i>AIRE</i>  | <input type="checkbox"/> Fatal Infantile Lactic Acidosis w/mtDNA Depletion <i>SUCLG1</i> | <input type="checkbox"/> <i>POLG1</i> Related Disorders                         |
| <input type="checkbox"/> Arginase Deficiency <i>ARG1</i>                               | <input type="checkbox"/> Focal Dermal Hypoplasia <i>PORCN</i>                            | <input type="checkbox"/> Purine Nucleoside Phosphorylase Deficiency             |
| <input type="checkbox"/> Argininosuccinic Aciduria <i>ASL</i>                          | <input type="checkbox"/> Fragile X Syndrome  | <input type="checkbox"/> Pyruvate Dehydrogenase Deficiency <i>PDHA1</i>         |
| <input type="checkbox"/> ARX Related Disorders   | <input type="checkbox"/> Guanidinoacetate Methyltransferase Deficiency <i>GAMT</i>       | <input type="checkbox"/> Rett Syndrome <i>MECP2</i>                             |
| <input type="checkbox"/> Arylsulfatase A Deficiency <i>ARSA</i>                        | <input type="checkbox"/> Hereditary Fructose Intolerance <i>ALDOB</i>                    | <input type="checkbox"/> RHD Molecular Typing                                   |
| <input type="checkbox"/> BCS1L Related Complex III Deficiency <i>BCS1L</i>             | <input type="checkbox"/> Huntington Disease  | <input type="checkbox"/> Rothmund-Thomson Syndrome <i>RECQL4</i>                |
| <input type="checkbox"/> Carbamoyl Phosphate Synthetase I Deficiency <i>CPS1</i>       | <input type="checkbox"/> Incontinentia Pigmentia   | <input type="checkbox"/> <i>RRM2B</i>   |
| <input type="checkbox"/> Cartilage Hair Hypoplasia <i>RMRP</i>                         | <input type="checkbox"/> L-Arginine:Glycine Amidinotransferase Deficiency <i>GATM</i>    | <input type="checkbox"/> <i>SMCD COL10A1</i>                                    |
| <input type="checkbox"/> <i>CDKL5</i> Related Atypical Rett Syndrome <i>CDKL5/STK9</i> | <input type="checkbox"/> Lesch-Nyhan Disease <i>HPRT1</i>                                | <input type="checkbox"/> <i>SCO1</i>  |
| <input type="checkbox"/> Charge Syndrome <i>CHD7</i>                                   | <input type="checkbox"/> Leukoencephalopathy <i>VWM EIF2B5</i>                           | <input type="checkbox"/> <i>SCO2</i>  |
| <input type="checkbox"/> Citrin Deficiency <i>SLC25A13</i>                             | <input type="checkbox"/> Lowe Syndrome <i>OCRL1</i>                                      | <input type="checkbox"/> Spinocerebellar Ataxia 1 (SCA1)                        |
| <input type="checkbox"/> Citrullinemia I ASS   | <input type="checkbox"/> MNGIE Syndrome (Thymidine Phosphorylase) <i>TP</i>              | <input type="checkbox"/> Spinocerebellar Ataxia 10 (SCA10)                      |
| <input type="checkbox"/> Cleidocranial Dysplasia <i>RUNX2</i>                          | <input type="checkbox"/> <i>MPV17</i>  | <input type="checkbox"/> <i>SURF1</i>   |
| <input type="checkbox"/> Coenzyme Q10 Deficiency <i>COQ2</i>                           | <input type="checkbox"/> Mucopolysaccharidosis Type I <i>IDUA</i>                        | <input type="checkbox"/> Thymidine Kinase <i>TK2</i>                            |
| <input type="checkbox"/> Coenzyme Q10 Deficiency <i>PDSS1</i>                          | <input type="checkbox"/> Mucopolysaccharidosis Type II <i>IDS</i>                        | <input type="checkbox"/> X-linked Ocular Albinism <i>GPR143</i>                 |
| <input type="checkbox"/> Coenzyme Q10 Deficiency <i>PDSS2</i>                          | <input type="checkbox"/> Myotonic Dystrophy  | X-linked Ichthyosis (STS Deficiency)  |
| <input type="checkbox"/> <i>COX10</i>  | <input type="checkbox"/> Nail-Patella Syndrome <i>LMX1B</i>                              | <input type="checkbox"/> FISH <input type="checkbox"/> Biochemical              |
| <input type="checkbox"/> Cystic Fibrosis <i>CFTR</i>                                   | <input type="checkbox"/> Noonan Syndrome <i>PTPN11</i>                                   | <input type="checkbox"/> Wolman Disease   |
| <input type="checkbox"/> DGUOK (Deoxyguanosine Kinase)                                 | <input type="checkbox"/> Optic atrophy type 1 <i>OPA1</i>                                |   |

**POLICY INFORMATION**

\*TURNAROUND TIME NOTICE: Samples received after 3 pm may be subject to an increase in turnaround time.

**REFLEX POLICY:** The following will be performed by reflex at no additional charge; AchE when AF-AFP is elevated; Fetal HGB when AF-AFP is elevated and amniotic fluid is bloody; CF5T when R117H CF mutation is present.

**NOTICE FOR PRENATAL BIOCHEMICAL AND DNA TESTS:** Please be aware that our specimen requirements and quality control measures are compliant with American College of Medical Genetics (ACMG) Standards and Guidelines for Clinical Genetics Laboratories. While these requirements are intended to provide the highest level of assurance that a single laboratory can offer, the ideal practice to assure the accuracy of prenatal diagnostic testing is through duplicate testing conducted by independent laboratories. We recommend that referring medical professionals make the necessary arrangements for these two independent analyses for their patients prior to performing the prenatal diagnostic procedure.

Physician/Counselor Acknowledgement: \_\_\_\_\_ 6/12/2008

**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): \_\_\_\_/\_\_\_\_/\_\_\_\_