BCM-MEDICAL GENETICS LABORATORIES

PHONE: 800-411-GENE | FAX: 713-798-2787 | www.bcmgeneticlabs.org

SHIP TO: Medical Genetics Laboratories
Baylor College of Medicine
2450 Holcombe, Grand Blvd. -Receiving Dock
Houston, TX 77021-2024
Phone: 713-798-6555

CYTOGENETICS REQUISITION

PATIENT INFORMATION

NAME: _____ (LAST NAME) _____ (FIRST NAME) ___ (MI)

DATE OF BIRTH: ___ / ___ / ___ (MM / DD / YY)

GENDER (Please select one): ☐ FEMALE ☐ MALE ☐ UNKNOWN

DATE OF COLLECTION: ___ / ___ / ___ (MM / DD / YY)

SAMPLE TYPE (Please select one): ☐ BLOOD ☐ TISSUE ☐ OTHER (Specify): _____

HOSPITAL#: _____

ACCESSION#: _____

REPORTING INFORMATION

PHYSICIAN: _____

INSTITUTION: _____

PHONE: _____ FAX: _____

EMAIL (INTERNATIONAL CLIENT REQUIREMENT): _____

ADDITIONAL PROFESSIONAL REPORT RECIPIENTS

NAME: _____

PHONE: _____ FAX: _____

NAME: _____

PHONE: _____ FAX: _____

INDICATION FOR STUDY

CMA OPTIONS MOST APPROPRIATE 1ST TIER TEST FOR INDICATIONS BELOW:

- ☐ AUTISM SPECTRUM
- ☐ DEVELOPMENTAL DELAY
  - ☐ MILD ☐ MODERATE ☐ SEVERE
- ☐ DYSMORPHIC FEATURES
- ☐ FAILURE TO THRIVE
- ☐ MULTIPLE CONGENITAL ANOMALIES
- ☐ SEIZURE DISORDER
- ☐ OTHER (Specify): _____

CHROMOSOMES/FISH MOST APPROPRIATE 1ST TIER TEST FOR INDICATIONS BELOW:

- ☐ AUTOSOMAL TRISOMIES
- ☐ AMBIGUOUS GENITALIA
- ☐ INFERTILITY
- ☐ KLINEFELTER/TURNER
- ☐ MULTIPLE MISCARRIAGES
- ☐ FETAL DEMISE
- ☐ OTHER (Specify): _____

CHROMOSOMAL MICROARRAY ANALYSIS (CMA) OPTIONS

☐ 8665 CMA-HR+SNP screen (comprehensive)
(340K High Resolution Copy Number probes Plus 60K SNP probes (UPD/AOH))
Specify Gene of Interest: _____
If UPD suspected, specify chromosome: _____

☐ 8655 CMA-HR (180K High Resolution Copy Number ≥30Kb)
Specify Gene of Interest: _____

☐ 8650 CMA-CytoScan HD (2.6M probes)
If UPD suspected, specify chromosome: _____

☐ 9506 CMA-POC (paraffin-embedded tissue only)

☐ PARENTAL STUDIES RECOMMENDED IN CHILD'S CMA REPORT (Attach copy.)
- ☐ Mother (Full Name): _____
  - ☐ ASYMPTOMATIC ☐ SYMPTOMATIC (attach summary of findings)
- ☐ Father (Full Name): _____
  - ☐ ASYMPTOMATIC ☐ SYMPTOMATIC (attach summary of findings)

CYTOGENETIC TESTING OPTIONS

☐ 8600 Chromosome Analysis

☐ 8480 FISH for SRY - Related Phenotypes (Metaphase & Interphase Cells)*

☐ 8425 Rapid FISH - AneuVysion®: +13/+18/+21/X/Y (Interphase Cells ONLY)
ONE of the following tests MUST accompany the 8425 request.

OR
- ☐ 8665 CMA-HR+SNP screen (comprehensive)
- ☐ 8655 CMA-HR
- ☐ 8600 Chromosome Analysis

☐ 8426 Rapid FISH - Sex Chromosome: X/SRY (Interphase Cells ONLY)
ONE of the following tests MUST accompany the 8426 request.

OR
- ☐ 8665 CMA-HR+SNP screen (comprehensive)
- ☐ 8655 CMA-HR
- ☐ 8600 Chromosome Analysis

*Testing on Metaphase Cells require cell culturing

*** ADDITIONAL FISH OPTIONS FOUND ON PAGE 2 ***

REQUIRED: NEW YORK STATE PHYSICIAN SIGNATURE OF CONSENT

I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested. I have answered this person's questions. I have obtained informed consent from the patient or their legal guardian for this testing.

Physician's Printed Name: _____ Physician's Signature: _____ Date (MM/DD/YY): _____

LAST UPDATED: 9/26/2014

BCM-MEDICAL GENETICS LABORATORIES

PHONE: 800-411-GENE | FAX: 713-798-2787 | www.bcmgeneticlabs.org

SHIP TO: Medical Genetics Laboratories
Baylor College of Medicine
2450 Holcombe, Grand Blvd. -Receiving Dock
Houston, TX 77021-2024
Phone: 713-798-6555

CYTOGENETICS REQUISITION

NAME: _____ (LAST NAME) _____ (FIRST NAME) ___ (MI) DATE OF BIRTH: ___ / ___ / ___ (MM / DD / YY) GENDER (Please select one): ☐ FEMALE ☐ MALE ☐ UNKNOWN

FISH STUDIES

☐	8457	Adrenal Hypoplasia Congenita
☐	8458	JAG1-Related Alagille Syndrome
☐	8459	Angelman Syndrome
☐	8460	Beckwith-Wiedemann Syndrome
☐	8462	Charcot-Marie-Tooth Neuropathy
☐	8464	Cri-Du-Chat Syndrome
☐	8440	DiGeorge/Velocardiofacial Syndrome (22q and 10p) Panel
☐	8486	DiGeorge/Velocardiofacial Syndrome Type I (22q)
☐	8465	DiGeorge/Velocardiofacial Syndrome Type II (10p)
☐	8466	Glycerol Kinase Deficiency
☐	8467	Hereditary Neuropathy With Liability To Pressure Palsies
☐	8468	LIS1-Associated Lissencephaly
☐	8469	Kallmann Syndrome
☐	8430	Langer-Giedion Syndrome (EXT1 and TRPS1)
☐	8470	Microphthalmia With Linear Skin Lesion (MLS/MIDAS)
☐	8471	Miller-Dieker Syndrome
☐	8435	Multiple Exostoses (EXT1 and EXT2) Panel
☐	8472	Multiple Exostoses Type I (EXT1)
☐	8473	Multiple Exostoses Type II (EXT2)
☐	8474	Neurofibromatosis Type I
☐	8456	1p36 Deletion Syndrome
☐	8476	Prader-Willi Syndrome
☐	8477	Rubinstein-Taybi Syndrome
☐	8478	Smith-Magenis Syndrome
☐	8479	Sotos Syndrome
☐	8480	SRY-Related Phenotypes
☐	8482	Trichorhinophalangeal Syndrome Type I
☐	8450	WAGR (WT1 and PAX6) FISH Panel
☐	8483	Williams Syndrome
☐	8455	Wilms Tumor (WT1)
☐	8484	Wolf-Hirschhorn Syndrome
☐	8485	X-linked Ichthyosis

LAST UPDATED: 9/26/2014

BCM-MEDICAL GENETICS LABORATORIES

PHONE: 800-411-GENE | FAX: 713-798-2787 | www.bcmgeneticlabs.org

SHIP TO: Medical Genetics Laboratories
Baylor College of Medicine
2450 Holcombe, Grand Blvd. -Receiving Dock
Houston, TX 77021-2024
Phone: 713-798-6555

CYTOGENETICS REQUISITION

BILLING INFORMATION

IMPORTANT NOTICE: ONE OF THE THREE FOLLOWING BILLING OPTIONS MUST BE INDICATED BELOW.
PLEASE FORWARD ALL BILLING QUESTIONS TO: MEDGENBILLING@BCM.EDU

PATIENT INFORMATION

PATIENT NAME (LAST,FIRST, MI): _____ PATIENT DATE OF BIRTH (MM/DD/YY): _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: _____ EMAIL: _____

☐ PAYMENT OPTION 1 - INSTITUTION

INSTITUTION NAME: _____ INSTITUTION CODE: _____

CONTACT NAME: _____ EMAIL (REQUIRED): _____

BILLING ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: _____ FAX: _____

☐ PAYMENT OPTION 2 - SELF-PAY (PAYMENT MUST ACCOMPANY SAMPLE)

☐ CREDIT CARD (PLEASE SELECT ONE): ◯ AMEX ◯ DISCOVER ◯ MC ◯ VISA

VALID CARD #: _____ EXPIRATION DATE (MM/YY): _____ CVC CODE: _____

BILLING ADDRESS: _____ CITY, STATE, ZIP: _____

CARDHOLDER PRINTED NAME: _____ CARDHOLDER SIGNATURE: _____

☐ CHECK/MONEY ORDER: CHECK/MONEY ORDER #: _____ AMOUNT ENCLOSED: _____

☐ PAYMENT OPTION 3 - INSURANCE

PROVIDE A LEGIBLE PHOTOCOPY OF THE FRONT & BACK OF THE INSURANCE CARD OR HMO/MEDICAID HMO AUTHORIZATION/REFERRAL.

Please refer to the Financial Policy at www.bcmgeneticlabs.org for complete insurance filing information and managed care contract list. Insurance is filed to our contracted carriers as a client service 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 approved authorizations. BCM-Medical Genetic Laboratories cannot bill out-of-state welfare programs. We accept authorized Texas Medicaid HMO covered charges for genetic testing. Please contact our office prior to submitting a Texas Medicaid sample. Contact medgenbilling@bcm.edu with questions.

ORDERING PROVIDER: _____

ICD9 Diagnosis Code(s) - must be provided or insurance cannot be filed: _____

◯ PPO, POS, Commercial Insurance - Provide complete member information with legible front & back photocopy of insurance card.

◯ HMO - Provide approved authorization #: _____ and attach legible front & back photocopy of insurance card.

◯ Texas Medicaid HMO - Provide approved authorization #: _____ and contact Billing at 713-798-6555.

INSURED MEMBER'S INFORMATION

MEMBER NAME (Last, First, MI): _____ MEMBER DATE OF BIRTH (MM/DD/YY): _____ GENDER: ◯ FEMALE ◯ MALE

MEMBER POLICY #: _____ MEMBER SS #: _____ MEMBER GROUP #: _____

INSURANCE CO. NAME: _____ PHONE: _____

INSURANCE CO. ADDRESS: _____ CITY, STATE, ZIP: _____

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, DEDUCTIBLES, OR NON-AUTHORIZED SERVICES AND REMAINING BALANCES AFTER INSURANCE REIMBURSEMENT. 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/YY): _____