Place Patient label h	ere				ic/Adult Re			
(Place additional la	bels on the bac	k of requisition)		See Separate Prenatal ar	-		ions	
	- 0:			Cincinnati Chi	ildren's			
	Cin	cinnati ildren's		Cytogenetic and Molecu				
	Ch	ildren's		3333 Burnet Ave TCHRF 104 For test inquiries or courier			3039	
		al Medical Cente	-	Phone 513-636-4474 or F.	•			
	Hospit	al Medical Cente	r	web site : www.cincinnatic			ics	
				☐ Patient Presented for L	ab Draw	☐ Specir	nen Only	
1. Patient / Physi	ician Inform	ation						
Specimen date:	Specimen time:	Patient Name: (Last,	First, Mid. Int.)			Sex:	Date of Birth:	
1 1	:						1 1	
Hospital MR #:	Referring Institution:		Referring Physician:	Physician Phone:		Physician	FAX:	
Call Abnormal Results to:	<u>I</u>	Phone:	PHYSICIAN SIGNATUR	RE: (required)				
		<u> </u>	<u>_</u>					
2. Specimen Typ	е				1			
☐ Peripheral Blood	d specimen requir	ements below			☐ Skin Bi	iopsy		
3 mLs NaHep AND		3 mLs EDTA	3 mLs NaHep	5-10mLs NaHep	Site:			
3 mLs EDTA		NEEDED for ALL Molecular Genetics Tests	NEEDED for	NEEDED for			e for Fanconi Anemia	
NEEDED for SNP Micro Testing with or without	oarray	Molecular Genetics resis	Chromosome or FISH Testing	Fanconi Anemia Chromosome Breakage Testing	breakage study)	<u> </u>		
chromosomes			riori resuing	Breakage results	☐ Other:			
3. Tests Request	ed							
☐ Mental Retardation	n/Developmen	tal Delay Panel (3 mLs i	laHep and 3 mLs EDTA)	Molecul	ar Genetic T	Testing		
Fragile X Testing				Creatine deficiency syndrome test	ts:			
High resolution chron	nosome analysis			☐ GATM (AGAT deficiency) ☐ SI	LC6A8 (CTD)	□ GA	MT deficiency	
Reflex* SNP Microar	ray if chromosom	ne analysis is normal		☐ Fragile X Testing				
				☐ <i>MECP2</i> (RETT Syndrome)				
	Cytogen	etic Testing		☐ Prader-Willi/Angelman -Methylation	on PCR Analysi	s		
☐ Routine Chromoson	ne Analysis			FISH Tests: se	ee website fo	r comple	te list	
Reflex* STAT (2-3 day)	•			☐ 1p36 Deletion Syndrome (1p)				
Reflex* to mosaicism so by laboratory based on		omosome/mosaic aneuploid ed	y abnormality suspected	☐ Wolf-Hirschhorn Syndrome (4p)			
,				☐ Cri du Chat (5p)				
☐ High Resolution Chi		-		☐ Williams Syndrome (7q)				
Reflex* STAT (2-3 day)	•			☐ Duplication 15q11.2 (PWS probe)				
by laboratory based on		omosome/mosaic aneuploid ed	y abnormality suspected	☐ Prader-Willi/Angelman Syndror	ne (15q)			
				☐ Smith-Magenis (17p)				
☐ SNP Microarray - Co	onstitutional			☐ Miller-Dieker (17p)				
□ Chromosome Mosaicism Study - Routine Chromosome Analysis			□ DiGeorge/VCFS (22q)					
□ Reflex* SNP Microarray if chromosome results are normal			☐ Kallman Syndrome (Xp)					
☐ Reflex* Routine Chr	romosome Anal	ysis if SNP Microarray	is normal	□ X-linked Ichthyosis/STS Deficiency (Xp)				
		Breakage study (5-10ml ing options, please see FA req		☐ OTHER FISH (please call laboratory)	:			
O41-	T 4i	N		Available Autism Spectrum Disord	lar EICH Braha		SH 15q	
		Please call laborator	у	Available Autism Spectrum Disord	iei rion rione	:. U FI	on toq	
☐ Family Study (plea	. ,,	£ II _		Sex determination/Ambiguous ger	nitalia:			
☐ Cell culture, stora								
☐ Special Study:				☐ Xp11.1p11.1/Yp11.3 ☐ X/Y ce	ntromeres (Xp	011.1q1.1/	Yp11.1q11.1)	
	r lesting (in			RED for processing)				
MEDICAL/PHYSICAL □ Amenorrhea : 1° or	2°	□ Feeding difficulties□ Hydrocephalus	LEARNING/BEHAVI □ Mental Retardati		nev			
□ Asphyxia, Hypoxia, NC		□ Hypotonia	□ ADD	□ Family history MR	ж			
□ Autism		□ MRI, Abnormal	□ ADHD	□ Fam Hx Genetic Cor	ndition:			
□ Autism Spectrum Disor		□ Macrocephaly	□ Aphasia					
□ Congenital Heart anom□ Developmental Delay	naly	☐ Microcephaly☐ PDD-NOS	□ Apraxia□ Language Disoro	der □ Consanguinity (descri	be relationshin).			
□ Dysmorphic Features		□ Seizures, Convulsions		□ Known chromosome		relationship):bnormality		
□ Encephalopathy		□ Sensory Disturbance		Other (ICD-9 Code):				
□ Failure to Thrive		□ Short Stature	_,					
		g will be performed at						
				sicians when ordering tests that will be paid under fe dically necessary for treatment and diagnosis of the				
Feb 2011	p. ogram uccillo	0 (./	(=) .casonable (5) IIIe	,cocca, .or a camena and diagnosis of the	F20000 (4) 1100 101 5	y pu	F-1-30.	

For laboratory use only: tubes: type: volume: initials: date/time:

Please complete billing information on page 2. Both pages of requisition must be completed before sample can be processed.

culture:

Dilling Information

billing information	
Patient Name Last/First	
DOB	
Choose one method of payment	
□ Patient Billing	
\square Check Enclosed \square Money Order	☐ Credit Card



Cincinnati Children's Hospital Medical Center 3333 Burnett Avenue Cincinnati, OH 45229

Phone: 513-636-4474 Fax: 513-636-4373 www.cincinnatichildrens.org

		(visa, ivic, Aivi.exp.,	DISC.)
Credit Card	Number		
Card Holde	r Name		
Expiration [Date		
Signature			
	g Institution		
Institution			
Address			
City/State/Z	ip		
Accounts Pa	ayable Contact Name		
Phone			
Fax			
Email			

☐ Insurance / Policy Holder Information*

Name		
DOB	Gender	
Authorization Number		
Insurance Name		
Insurance Address		
City/State/Zip		
Insurance ID Number		
Group Number		
Insurance Phone Number		

- * Please Note:
- 1. Insurance can only be billed if requested at the time of service.
- 2. Acceptable forms of insurance are:
 - Commercial
- Ohio, Indiana or Kentucky Medicaid Exceptions must be pre-arranged with our billing staff. Please call 866-450-4198.

Medical Necessity Regulations: At the government's request, the Molecular Genetics Laboratories would like to remind all physicians that when ordering tests that will be paid under federal health care programs, including Medicare and Medicaid programs, that these programs will pay only for those tests the relevant program deems to be (1) included as covered services, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient, and (4) not for screening purposes.

☐ Patient signed completed ABN