Place Patient label here

(Place additional labels on the back of requisition)

Cincinnati Children's Hospital Medical Center

Pediatric/Adult Requisition

See Separate Prenatal and Oncology Requisitions

Cincinnati Children's

Cytogenetic and Molecular Laboratories
3333 Burnet Ave TCHRF 1042 Cincinnati, OH 45229-3039
For test inquiries or courier service please call:
Phone 513-636-4474 or FAX 513-636-4373
web site : www.cincinnatichildrens.org/cytogenetics

☐ Patient Presented for Lab Draw ☐ Specimen Only

1. Patient / Physician Information

Specimen date: / /	Specimen time: :	Patient Name: (Last, First, Mid. Int.)	Sex:	Date of Birth: / /

Hospital MR #:	Referring Institution:	Referring Physician:	Physician Phone:	Physician FAX:

Call Abnormal Results to:	Phone:	**PHYSICIAN SIGNATURE:** (required)

2. Specimen Type

☐ **Peripheral Blood** specimen requirements below

3 mLs NaHep AND 3 mLs EDTA	**3 mLs EDTA**	**3 mLs NaHep**	**5-10mLs NaHep**
NEEDED for SNP Microarray Testing with or without chromosomes	NEEDED for ALL Molecular Genetics Tests	NEEDED for Chromosome or FISH Testing	NEEDED for Fanconi Anemia Chromosome Breakage Testing

☐ **Skin Biopsy**
Site: _____
(unacceptable speciment type for Fanconi Anemia breakage study)

☐ **Other:**

3. Tests Requested

☐ **Mental Retardation/Developmental Delay Panel** (3 mLs NaHep and 3 mLs EDTA)
Fragile X Testing
High resolution chromosome analysis
Reflex* SNP Microarray if chromosome analysis is normal

Cytogenetic Testing

☐ **Routine Chromosome Analysis**
Reflex* STAT (2-3 day) prelim result on infants <1 month
Reflex* to mosaicism study when sex chromosome/mosaic aneuploidy abnormality suspected by laboratory based on indications provided

☐ **High Resolution Chromosome Analysis**
Reflex* STAT (2-3 day) prelim result on infants <1 month
Reflex* to mosaicism study when sex chromosome/mosaic aneuploidy abnormality suspected by laboratory based on indications provided

☐ **SNP Microarray - Constitutional**
☐ **Chromosome Mosaicism Study - Routine Chromosome Analysis**
☐ **Reflex*** SNP Microarray if chromosome results are normal
☐ **Reflex*** Routine Chromosome Analysis if SNP Microarray is normal
☐ **Fanconi Anemia (FA) Chromosome Breakage study (5-10mL NaHep)**
(For FA complementation and molecular testing options, please see FA requisition)

Other Testing - Please call laboratory

☐ Family Study (please specify):_____
☐ Cell culture, storage & freezing of cells
☐ Special Study:_____
☐ Other:_____

Molecular Genetic Testing

Creatine deficiency syndrome tests:
☐ *GATM* (AGAT deficiency) ☐ *SLC6A8* (CTD) ☐ *GAMT* deficiency

☐ Fragile X Testing
☐ *MECP2* (RETT Syndrome)
☐ Prader-Willi/Angelman -Methylation PCR Analysis

FISH Tests: see website for complete list

☐ **1p36 Deletion Syndrome (1p)**
☐ **Wolf-Hirschhorn Syndrome (4p)**
☐ **Cri du Chat (5p)**
☐ **Williams Syndrome (7q)**
☐ **Duplication 15q11.2 (PWS probe)**
☐ **Prader-Willi/Angelman Syndrome (15q)**
☐ **Smith-Magenis (17p)**
☐ **Miller-Dieker (17p)**
☐ **DiGeorge/VCFS (22q)**
☐ **Kallman Syndrome (Xp)**
☐ **X-linked Ichthyosis/STS Deficiency (Xp)**
☐ **OTHER FISH (please call laboratory):**_____

Available Autism Spectrum Disorder FISH Probe: ☐ **FISH 15q**

Sex determination/Ambiguous genitalia:
☐ **Xp11.1p11.1/Yp11.3** ☐ **X/Y centromeres (Xp11.1q1.1/Yp11.1q11.1)**

4. Indications for Testing (Indication or ICD-9 Codes REQUIRED for processing)

MEDICAL/PHYSICAL
- ☐ Amenorrhea : 1° or 2°
- ☐ Asphyxia, Hypoxia, NOS
- ☐ Autism
- ☐ Autism Spectrum Disorder
- ☐ Congenital Heart anomaly
- ☐ Developmental Delay
- ☐ Dysmorphic Features
- ☐ Encephalopathy
- ☐ Failure to Thrive
- ☐ Feeding difficulties
- ☐ Hydrocephalus
- ☐ Hypotonia
- ☐ MRI, Abnormal
- ☐ Macrocephaly
- ☐ Microcephaly
- ☐ PDD-NOS
- ☐ Seizures, Convulsions
- ☐ Sensory Disturbance
- ☐ Short Stature

LEARNING/BEHAVIOR
- ☐ Mental Retardation
- ☐ ADD
- ☐ ADHD
- ☐ Aphasia
- ☐ Apraxia
- ☐ Language Disorder

FAMILY HISTORY
- ☐ Family history Epilepsy
- ☐ Family history MR
- ☐ Fam Hx Genetic Condition: _____
- ☐ Consanguinity (describe relationship): _____
- ☐ Known chromosome abnormality

Other (ICD-9 Code): _____

***REFLEX POLICY: Any reflex testing will be performed at additional charge**

Medical Necessity Regulations- At the government's request the Genetics Laboratory would like to remind all physicians when ordering tests that will be paid under federal health including Medicare and Medicaid, 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 treatment and diagnosis of the patient (4) not for screening purposes.
Feb.2011

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

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

Billing Information

Patient Name Last/First

DOB

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

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

Choose one method of payment

☐ Patient Billing

☐ Check Enclosed ☐ Money Order ☐ Credit Card (Visa, MC, AM.Exp., Disc.)

Credit Card Number

Card Holder Name

Expiration Date

Signature

☐ Referring Institution

Institution

Address

City/State/Zip

Accounts Payable 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

ALL INFORMATION MUST BE COMPLETED BEFORE SAMPLE CAN BE PROCESSED