Place Patient label here
(Place additional labels on the back of requisition)

Prenatal Cytogenetic Requisition

See Separate Pediatric/Adult and Oncology Requisition

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:
Physician Address:	Lab Address:	Lab phone:	**PHYSICIAN SIGNATURE:** (required)	
Genetic Counselor or RN (to call with abnormal results)			GC/RN Phone:	

2. Billing Information - Please see second page of requisition

3. Specimen Type

☐ Amniotic Fluid _____ mls collected ☐ Products of Conception ☐ Peripheral Blood
☐ CVS (maternal sample needed: 3 mL blood in EDTA **OR** 2 buccal swabs) ☐ Other:_____

4. Pregnancy Data

Ultrasound date:	Gestational Age: wks days
LMP:	Gestational Age: wks days

G_____P_____SAB_____TAB_____
Multiple Gestation: (separate requisitions)

5. Diagnosis (Diagnosis or ICD-9 Code REQUIRED)

☐ Abnormal MS-AFP ☐ Advanced Maternal Age ☐ Molar pregnancy
☐ IUGR ☐ Consanguinity: _____ ☐ Infertility
☐ Fetal Anomalies ☐ Fetal demise ☐ Other (ICD-9 Code) _____
☐ Cystic Hygroma ☐ Recurrent Miscarriage _____
☐ Abnormality on Ultrasound:

6. Cytogenetic Tests

☐ **Chromosome Analysis** (Blood, Amnio, CVS, Tissue)
Amnio Includes: order for AFP if gest age 13W0D-24W6D
order for ACHE if gest age >24W6D
order to reflex to ACHE if AFP is abnormal
☐ Do **not** include AFP or ACHE testing in order
☐ ACHE Testing in addition to AFP
☐ Reflex to Microarray if chromosome analysis is normal
Parental samples required for MA on CVS/amnio:
5 mL blood in EDTA and 5mL blood in NaHep
OR four (4) buccal swabs for each parent
Name of infant's Father:_____ DOB:_____

FISH Testing
☐ Prenatal Aneuploidy FISH Panel (Chr. 13, 18, 21, X, Y)
☐ Velocardiofacial (DiGeorge) Syndrome (deletion 22q11.2)
☐ Other FISH: _____
(contact lab or see website for FISH probe availability)

☐ **SNP Microarray** (Blood, Amnio, CVS, Tissue)
Parental samples required for CVS/amnio:
5 mL blood in EDTA and 5mL blood in NaHep
OR four (4) buccal swabs for each parent

☐ **Cell Culture, Storage & Freezing of Cells**
(# of flasks_____)

☐ **Thaw/Expansion of Cells**

☐ **Special Study:** ***(please call lab prior to ordering)***
_____

7. Molecular Testing

☐ Fragile X
☐ Prader-Willi / Angelman Methylation
☐ Identity Test (STR)
☐ Maternal cell contamination ☐ Twin zygosity

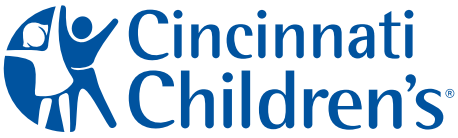
Inherited Thrombophilia Testing
☐ Factor V (Leiden)
☐ Thrombophilic Polymorphism Panel
(MTHFR-677C>T, Factor V- Leiden, Factor II-Prothrombin 2021, PAI-1)

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) reaasonable (3) medically necessary for treatment and diagnosis of the patient (4) not for screening purposes.

Dec-11

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.

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☐ Patient signed completed ABN

ALL INFORMATION MUST BE COMPLETED BEFORE SAMPLE CAN BE PROCESSED