Place Patient Label in this Box

SEND SPECIMEN AND REQUISITION TO UNIVERSITY HOSPITAL LAB.

CINCINNATI CHILDREN'S HOSPITAL CONSTITUTIONAL & PRENATAL REQUISITION FOR UC Health University Hospital

Lab Phone: 513-636-4474 Mon-Fri 8a-6p
After Hours Phone: 513-636-7355
Scheduled Pick-Ups: M-F 5:30AM, 10:30AM, 2:45PM, 5:30PM
SAT 5:30 AM
Nights, Weekends & Holidays call United (513) 961-2444 Act. # 373
Toll free: (877) 423-6879

COLLECTION INFO. (REQUIRED):
Draw Date: _____
Draw Time: _____
Initial: _____

SPECIMEN TUBES:
☐ LAV (EDTA) ☐ GRN (NaHep)
☐ TUBE W/ MEDIUM
☐ OTHER:

PRINT CLINICIAN NAME & CREDENTIALS (REQUIRED)
_____

FAX/CALL RESULTS TO: _____

SPECIMEN TYPE:
☐ Amniotic fluid _____ mL collected
☐ CVS (maternal sample needed: 3 mL blood EDTA or 2 buccal swabs)
☐ Fetal Blood
☐ Fetal Urine
☐ Peripheral Blood
☐ Cytstic hygroma fluid
☐ Products of Conception
☐ Skin Biopsy, Site:_____
☐ Other:_____

UNIVERSITY HOSPITAL LAB INSTRUCTIONS:

1) Order in Horizon using indicated test code or CREF (enter test name as comment)
2) Place on Childrens TL; Record TL# on log sheet
3) Store in appropriate temp. bin for Children's courier
4) Send original req with specimen; Retain copy with daily orders

SUSPECTED DIAGNOSIS / INDICATIONS (REQUIRED)

☐ Screen positive for Down Syndrome
☐ Screen positive for Trisomy 13 or 18
☐ Screen positive for Neural Tube Defect
☐ Advanced Maternal Age
☐ IUGR
☐ Fetal Anomalies
☐ Cystic Hygroma
☐ Abnormality on Ultrasound
☐ Consanguinity
☐ Fetal Demise
☐ Recurrent Miscarriage
☐ Molar Pregnancy
☐ Infertility
☐ Congenital Heart Anomaly
☐ Dysmorphic Features
☐ Encephalopathy
☐ Failure to Thrive
☐ Feeding Difficulties
☐ Hydrocephalus
☐ Hypotonia
☐ Macrocephaly
☐ Microcephaly
☐ Hemophagocytic Lymphohistiocytosis (HLH)
☐ Intellectual Disability
☐ Other (IDC-9 Code):_____

PATIENT HISTORY:

TISSUE TESTING:

20-30 mg in media or in a piece of sterile saline guaze, room temp
☐ Tissue Chromosome Analysis
Wks Gestation_____ Origin of Tissue_____
☐ Cell Culture, Storage and Freezing of Cells
☐ Thaw / Expansion of Cells
☐ Special Study (please call laboratory)
☐ Reflex to SNP Microarray

GENETIC PHARMACOLOGY SERVICES

☐ Psychiatry Pharmacogenetics Expanded Panel
☐ TPMT Genotype Analysis
☐ Opioid CYP2D6 Pharmacogenetics Panel
☐ CYP2C19
☐ CYP2C9
☐ CYP2D6
☐ CYP2D6/CYP2C19
☐ Individual Drug
Specify drug: _____
(See http://gps.cchmc.org for list)

PRENATAL TESTING:

Amniotic Fluid 20-25 mL, room temp
CVS 10-100 mg in sterile media, room temp
☐ Prenatal Chromosome Analysis includes AFP for 13W0D-23W6D*, ACHE for 22W0D-24W6D*; reflex to ACHE if AFP is abnormal
Required Information:
Ultrasound Date:_____
Gestational Age _____ LMP_____
G_____ P_____ SAB_____ TAB_____
☐ Prenatal FISH Panel (13, 18, 21, X, Y)
☐ FISH for Velocardiofacial (DiGeorge) Syndrome (Deletion 22q11.2)
☐ Special Study (please call laboratory, 636-4474)
☐ Maternal Cell Contamination
☐ Twin Zygosity

Need for each Parent: 5 mL blood in EDTA and 5 mL blood in NaHep or one saliva kit for any prenatal SNP microarray, room temp
Name of infant's father_____
DOB:_____
☐ SNP Microarray
☐ Reflex to SNP Microarray

INFECTIONS DISEASES:

(For CCHMC use only: client code 3072)
0.5 mL amniotic fluid in a sterile tube (no anticoagulant), refrigerated:
☐ CMV (Horizon: CMVQUAL)
☐ Toxoplasma Gondii (Horizon: TOXOPCR)
☐ Parvovirus B19
☐ Herpes Simplex Virus QUAL (Horizon: HSVDNA)

POSTNATAL/CONSTITUTIONAL TESTING:

3-5 mL Blood in NaHep, room temp
☐ Routine Blood Chromosome Analysis
☐ High Resolution Blood Chromosome Analysis
Reflex STAT (2-3 day) prelim results on infants <1 month
Reflex to mosaicisim study when sex chromosome/mosaic aneuploidy abnormality suspected by laboratory based on indications provided
☐ Mosaicism Study
☐ FISH Specify:_____

3 mL Blood in NaHep and 3 mL Blood in EDTA, room temp
☐ SNP Microarray
☐ Reflex to SNP Microarray

3-5 mL Blood in EDTA, room temp
☐ Fragile X Testing
☐ MECP2 (RETT Syndrome)
☐ Prader-Willi / Angelman - methylation PCR Analysis
☐ Creatine Deficiency Disorder
  ☐ GATM (AGAT Deficiency)
  ☐ SLC6A8 (CTD)
  ☐ GAMT Deficiency

*Order for ACHE will be added for the following indications: suspected or known neural tube defect, screen positive for neural tube defect, any open fetal lesion. AFP and ACHE will not be ordered for the following indications: fetal demise, TRAP, TTTS or for any specimen type other than amniotic fluid.

DIAGNOSTIC IMMUNOLOGY LAB

Must be drawn Mon-Thur or Friday before 11 am:
☐ Perforin/Granzyme B (3mL EDTA) (Keep at room temp)(PERFGRA)
☐ Natural killer function (10mL NaHep*) (Keep at room temp)(NKFUN)
☐ Soluble IL-2R (3mL EDTA) (Keep at room temp)(SOLIL)

Must be drawn Mon-Wed or Thur before 11am:
☐ CD107a (10mL NaHep*)(Keep at room temp)(CDMOB)

* Volume assumes a normal absolute lymphocyte count (ALC). If the ALC is abnormal, please call the lab for adjusted volume requirements. 636-4685

OTHER TEST/SPECIAL INSTRUCTIONS

CLINICIAN SIGNATURE (REQUIRED) DATE

SIGNATURE OF PERSON COMPLETING FORM IF NOT CLINICIAN (REQUIRED) DATE

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