Cincinnati Children's

DIVISION OF HUMAN GENETICS
DIAGNOSTIC LABORATORIES
For courier service and/or inquiries, please contact 513-636-4474 • Fax: 513-636-4373
3333 Burnet Avenue, Room NRB 1013, Cincinnati, OH 45229
www.cincinnatichildrens.org/cytogenetics • Email: cytogenetics@cchmc.org
For Saturday delivery, please include "Dock 5" on the airbill

Teresa Smolarek, PhD
Director of the Cytogenetics Lab
Kejian Zhang, MD, MBA
Director of the Molecular Genetics Lab

PRENATAL CYTOGENETICS REQUISITION

All Information Must Be Completed Before Sample Can Be Processed

PATIENT INFORMATION

Patient Name: _____ , _____ , _____
Last First MI

MR#: _____

Date of Birth: ____ / ____ / ____ Gender: M☐ F☐

SAMPLE/SPECIMEN INFORMATION

SPECIMEN TYPE: ☐ Amniotic fluid ☐ Products of Conception
☐ Peripheral blood ☐ Cystic hygroma fluid ☐ CVS ☐ Fetal urine
☐ Other _____

SPECIMEN DATE: _____ / _____ / _____ TIME: _____

DRAWN BY: _____

*Phlebotomist must initial tube of specimen to confirm sample identity

PREGNANCY DATA: (Multiple gestation- separate requisitions)

Ultrasound date: ____ / ____ / ____ GA on US date: _____wks _____days

LMP: _____ GA by LMP: _____wks _____ days

G _____ P _____ SAB _____ TAB _____

LABORATORY TESTS ORDERED

☐ Prenatal Aneuploidy FISH Panel (FISH for 13, 18, 21, X and Y)
☐ Chromosome Analysis* (See page 2 for information on AF-AFP/ACHE orders)
☐ If chromosomes are normal, reflex to SNP microarray – Parental samples **recommended** for Prenatal Microarray
☐ SNP Microarray - Parental samples **recommended** for Prenatal Microarray

Parental Sample Information for Prenatal Microarray:
☐ Maternal sample included
☐ Paternal sample included
Father of fetus' name: _____ DOB: _____
☐ Maternal sample not collected
☐ Paternal sample not collected

☐ ACHE
☐ Do NOT include AFP or ACHE testing in order
☐ Velocardiofacial (DiGeorge) Syndrome (deletion 22q11.2) FISH
☐ Other FISH testing (please call lab for availability): _____
☐ Fragile X DNA testing
☐ Factor V (Leiden)
☐ Thrombophilic Polymorphism Panel
(MTHFR-677C>T, Factor V-Leiden, Factor II-Prothrombin G20210A, PAI-1)
☐ Maternal Cell Contamination by STR analysis
☐ Special Study (please call lab prior to ordering)
☐ Culture for possible future study: _____
☐ Send out testing (please include all information including laboratory requisition): _____

REFERRING PHYSICIAN

Physician Name (print): _____

Address: _____

Phone: (_____) _____ Fax: (_____) _____

Email: _____

Genetic Counselor/Lab Contact Name: _____

Phone: (_____) _____ Fax: (_____) _____

Email: _____

_____ Date: ____/ ____/ _____
Referring Physician Signature (REQUIRED)

INDICATIONS/DIAGNOSIS/ICD-9 CODE

☐ Abnormal maternal serum/first trimester screen. Increased risk of:
☐ NTD ☐ Down syndrome ☐ Trisomy 18 ☐ other (specify): _____
☐ Abnormal fetal ultrasound: _____
_____
☐ Recurrent Miscarriage
☐ Family History: _____
☐ Advanced Maternal Age
☐ Infertility
☐ Consanguinity (please specify relationship): _____
☐ Other (ICD-9 Code) _____

BILLING INFORMATION

Please call 1-866-450-4198 with questions.

☐ PATIENT BILLING/SELF PAY

Please call 1-866-450-4198 for options

☐ INSTITUTION BILL

Institution: _____
Address: _____
City/State/Zip: _____
Accounts Payable Contact Name: _____
Phone: _____
Fax: _____
Email: _____

☐ COMMERCIAL INSURANCE

Can only be billed if requested at time of service.
☐ Billing information attached - include a copy of insurance card/face sheet

Cancellation Policy: Tests can only be cancelled if laboratory is notified prior to the initiation of testing.

☐ Patient signed completed ABN

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.

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ADDITIONAL INFORMATION

SPECIMEN REQUIREMENTS

Tissue Testing:
20-30 mg in media or on a piece of sterile saline gauze (specimen should not be floating in saline).

Prenatal Testing:
Amniotic Fluid: 20-25 mL amniotic fluid
*Please note: amniotic fluid chromosome order includes (with additional charges): AF-AFP if gestational age 13W0D-23W6D and AF-ACHE if gestational age 22W0D-24W6D, order to reflex to ACHE if AFP is abnormal. 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 lesions. AFP and ACHE will not be ordered for the following indications: fetal demise, twin reversed arterial perfusion (TRAP), twin-twin transfusion syndrome (TTTS), or any specimen type other than amniotic fluid.

CVS:10-100 mg in sterile media.

Prenatal Microarray: Parental samples are recommended: 5 mL blood in EDTA and 5 mL blood in NaHep OR one saliva kit for each parent.

For any questions about specimen requirements, please call our laboratory at (513) 636-4474.

SHIPPING INFORMATION

Local courier is available; please call 513-636-4474 for information.

Shipping:
For samples that arrive **Monday-Friday:**
Cincinnati Children's
Cytogenetic and Molecular Laboratories
3333 Burnet Ave.
TCHRF 1042
Cincinnati, OH 45229-3039

For samples that arrive on **Saturday** (Please call laboratory to inform):
Cincinnati Children's
Cytogenetic and Molecular Laboratories
3333 Burnet Ave.
TCHRF 1042
DOCK 5
Cincinnati, OH 45229-3039