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

PEDIATRIC/ADULT TEST 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: ☐ Peripheral blood ☐ Skin biopsy (site): _____

☐ Other _____

Specimen Date: _____ / _____ / _____ Time: _____

Specimen Amount: _____

DRAWN BY: _____

*Phlebotomist must initial tube of specimen to confirm sample identity

INDICATIONS/DIAGNOSIS/ICD-9 CODE

Medical/Physical
- ☐ Amenorrhea: 1° or 2°
- ☐ Autism Spectrum Disorder
- ☐ Congenital heart anomaly
- ☐ Dysmorphic features
- ☐ Encephalopathy
- ☐ Failure to thrive
- ☐ Hydrocephalus
- ☐ Hypotonia
- ☐ MRI, abnormal
- ☐ Macrocephaly
- ☐ Microcephaly
- ☐ PDD-NOS
- ☐ Seizures, convulsions
- ☐ Short stature
- ☐ Other: _____

Learning/Behavior
- ☐ Developmental delay/ Intellectual disability
- ☐ ADD/ADHD
- ☐ Language disorder

Family History
- ☐ Family history ID
- ☐ Known chromosome abnormality
- ☐ Fam Hx genetic condition: _____
- ☐ Consanguinity (describe relationship): _____

REFERRING PHYSICIAN

Physician Name (print): _____

Address: _____

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

Email: _____

Genetic Counselor/Lab Contact Name: _____

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

Email: _____

_____ Date: ____/____/____

Referring Physician Signature (REQUIRED)

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

TEST(S) REQUESTED

Cytogenetic Testing

- ☐ Routine chromosome analysis*
- ☐ High resolution chromosome analysis*
- ☐ **Reflex*** SNP Microarray if chromosome results are normal
- ☐ SNP Microarray — Constitutional
- ☐ **Reflex*** Routine Chromosome Analysis if SNP Microarray is normal
- ☐ Chromosome mosaicism study — routine chromosome analysis
- ☐ Fanconi Anemia (FA) Chromosome Breakage study
- ☐ Bloom syndrome – Sister Chromatid Exchange (SCE) analysis

***For chromosome analysis:** reflex STAT (2-3 day) prelim results on infants <1 month. Reflex to mosaicism study when sex chromosome/ mosaic aneuploidy abnormality suspected by laboratory based on indications provided.

Molecular Genetic Testing (for full Molecular Genetics test menu, see website)

- ☐ Fragile X DNA testing
- ☐ Prader-Willi/Angelman — Methylation PCR analysis

*** Additional charge for reflex testing**

FISH Tests (other FISH probes available, see website for complete list)

- ☐ 1p36 Deletion Syndrome (1p)
- ☐ Williams Syndrome (7q)
- ☐ Prader-Willi/Angelman Syndrome (15q)
- ☐ DiGeorge/VCFS (22q)
- ☐ Xp11.1p11.1/Yp11.3
- ☐ X/Y centromeres (Xp11.1q1.1/Yp11.1q11.1)
- ☐ Other FISH (please call laboratory):_____

Other testing- please call

- ☐ Family study (please specify): _____
- ☐ Cell culture, storage & freezing of cells
- ☐ Special study/other: _____

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 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.

ADDITIONAL INFORMATION

SPECIMEN REQUIREMENTS

Fanconi Anemia Chromosome Breakage Study (please see Fanconi Anemia Requisition for molecular and complementation testing options):
5-10 mLs peripheral blood (NaHep)
5-10 mLs bone marrow (NaHep)
Skin biopsy

Bloom syndrome – Sister Chromatid Exchange (SCE) analysis:
3-5 mL blood (NaHep)

Routine/High Resolution Chromosome analysis:
3-5 mL blood (NaHep)

SNP Microarray:
3 mL blood (NaHep) **and** 3 mL blood (EDTA)

Fragile X DNA Testing:
3-5 mL blood (EDTA)

Prader-Willi/Angelman - methylation PCR analysis:
3-5 mL blood (EDTA)

FISH Tests:
3-5 mL blood (NaHep)

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