

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



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

<input type="checkbox"/> Peripheral Blood specimen requirements below	<input type="checkbox"/> Skin Biopsy
<input type="checkbox"/> 3 mLs NaHep AND 3 mLs EDTA NEEDED for SNP Microarray Testing with or without chromosomes	<input type="checkbox"/> 3 mLs EDTA NEEDED for ALL Molecular Genetics Tests
<input type="checkbox"/> 3 mLs NaHep NEEDED for Chromosome or FISH Testing	<input type="checkbox"/> 5-10mLs NaHep NEEDED for Fanconi Anemia Chromosome Breakage Testing
Site: _____ (unacceptable specimen type for Fanconi Anemia breakage study)	
<input type="checkbox"/> 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

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

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)

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): _____

Other Testing - Please call laboratory

Family Study (please specify): _____

Other: _____

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 <input type="checkbox"/> Amenorrhea : 1 ⁺ or 2 ⁺ <input type="checkbox"/> Asphyxia, Hypoxia, NOS <input type="checkbox"/> Autism <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Congenital Heart anomaly <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Dysmorphic Features <input type="checkbox"/> Encephalopathy <input type="checkbox"/> Failure to Thrive	<input type="checkbox"/> Feeding difficulties <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Hypotonia <input type="checkbox"/> MRI, Abnormal <input type="checkbox"/> Macrocephaly <input type="checkbox"/> Microcephaly <input type="checkbox"/> PDD-NOS <input type="checkbox"/> Seizures, Convulsions <input type="checkbox"/> Sensory Disturbance <input type="checkbox"/> Short Stature	LEARNING/BEHAVIOR <input type="checkbox"/> Mental Retardation <input type="checkbox"/> ADD <input type="checkbox"/> ADHD <input type="checkbox"/> Aphasia <input type="checkbox"/> Apraxia <input type="checkbox"/> Language Disorder	FAMILY HISTORY <input type="checkbox"/> Family history Epilepsy <input type="checkbox"/> Family history MR <input type="checkbox"/> Fam Hx Genetic Condition: _____ <input type="checkbox"/> Consanguinity (describe relationship): _____ Other (ICD-9 Code): _____
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***REFLEX POLICY: Any reflex testing will be performed at additional charge**

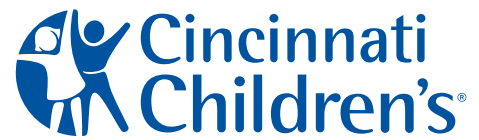
Medical Necessity Regulations- At the government's request the Genetics Laboratory would like to remind all physicians when ordering tests that will be paid under federal health including Medicare and Medicaid, these programs will pay only for those tests the relevant program deems to be (1) included 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

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

Phone: 513-636-4474

Fax: 513-636-4373

www.cincinnatichildrens.org

Referring Institution or MD

Institution
Address
City/State/Zip
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	

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Patient signed completed ABN

ALL INFORMATION MUST BE COMPLETED BEFORE SAMPLE CAN BE PROCESSED