



**CYSTIC FIBROSIS CARRIER
SCREENING REQUISITION**

MOLECULAR GENETICS LABORATORY

3333 Burnet Avenue, NRB 1042

Cincinnati, OH 45229-1933

Email: moleculargenetics@cchmc.org

For courier service and/or inquiries, please
contact: (513) 636-4474/ FAX #: (513)636-4373

PATIENT INFORMATION

PATIENT NAME: _____

SEX: M ___ F ___ DATE OF BIRTH _____

MEDICAL RECORD # _____

FAMILY HISTORY OF CF: ___ YES ___ NO
If yes, relationship: _____

ETHNICITY: Caucasian _____
Asian American _____
Hispanic American _____
African American _____
Other (Specify) _____

ORDERING PHYSICIAN

Phone _____ Fax _____

**PHYSICIAN SIGNATURE AND DATE
(REQUIRED)**

DATE _____

COUNSELOR/REFERENCE LAB

Phone _____ Fax _____

**INSURANCE INFORMATION
(complete information or attach)**

INSURANCE #1) _____

Subscriber ID _____

Group Name/Number _____

Address _____

INSURANCE #2) _____

Subscriber ID _____

Group Name/Number _____

Address _____

POLICY HOLDER/GUARANTOR (If different from self)

Name/Relationship _____

Address _____

DIAGNOSIS / ICD-9 CODE

Specimen Information:

- Blood Draw Date: _____
Specimen Requirements: No less than 2 mls. in a purple top EDTA tube
- Buccal Swab

Medical Necessity Regulations

At the government's request, the Cytogenetics and 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 included as covered services, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient, and (4) not for screening purposes.

BILLING INFORMATION

- Patient Billing
- Patient requests insurance be billed
- Check here if patient signed completed ABN
- Physician/Institution Account

Laboratory Use Only

Date/Time Received:

Received by:

Specimen Container:

Tubes: