Cincinnati Children's
changing the outcome together

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: _____

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 Reflex Test* (See page 2 for additional information):
☐ Aneuploidy FISH Panel (13, 18, 21, X and Y) with **Reflex** to:
☐ SNP Microarray on direct amniotic fluid If FISH is Normal **OR**
☐ Chromosome Analysis If FISH is ABNORMAL

Parental Sample Information for Prenatal Microarray (recommended):
☐ Maternal sample included
☐ Paternal sample included
Father of fetus' name: _____ DOB: _____

☐ Prenatal Aneuploidy FISH Panel (FISH for 13, 18, 21, X and Y)
☐ Chromosome Analysis*
☐ For Products of Conception, if sample fails to grow for chromosome analysis, reflex to microarray
☐ SNP Microarray*
☐ ACHE
☐ Do NOT include AFP or ACHE testing in order
☐ FISH testing (please call lab for availability): _____
☐ Maternal Cell Contamination (MCC) (maternal sample required)
☐ Fragile X (MCC required, contact the lab prior to shipment)
☐ Special Study (please call lab prior to ordering)
☐ **Special Study is the priority over microarray OR**
☐ **Microarray is the priority over special study**
☐ Special Study culture and send to[1]: _____
☐ Special Study culture and freeze: _____
☐ Thaw and Expand previous sample
☐ DNA extraction & storage (Cyto)

[1]If all requisition forms for recipient lab are not received within 1 week of our sample receipt, the sample will be frozen and stored. Please check with special study recipient lab for additional required materials (such as maternal sample) that must be sent with the proband sample.

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-10 CODE

☐ Abnormal maternal serum / first trimester screen / NIPS / NIPT
Increased risk of: _____
☐ Abnormal fetal ultrasound: _____
_____
☐ Recurrent Miscarriage
☐ Family History: _____
☐ Advanced Maternal Age
☐ Infertility
☐ Consanguinity (please specify relationship): _____
☐ Other (ICD-10 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

PLEASE NOTE:
- We will not bill Medicaid, Medicaid HMO, or Medicare except for the following: CCHMC Patients, CCHMC Providers, or Designated Regional Counties.
- If you have questions, please call 1-866-450-4198 for complete details.

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).
*Please note: When requested, original POC tissue can be returned after testing is completed (if available). Please contact the lab at 513-636-4474 for further details.

Prenatal Testing:
Amniotic Fluid: 25 mL amniotic fluid
*Please note:
- In order to perform SNP Microarray testing on direct amniotic fluid samples (without culturing the cells), we require 25 mL of amniotic fluid. If the sample is sufficient, we will automatically perform SNP Microarray on direct amniotic fluid samples. However, bloody samples (fluid or cell pellet), low volume/low cell count samples, and/or samples with additional special study orders may need to be cultured to obtain SNP Microarray results.
- Amniotic fluid chromosome or microarray order includes (with additional charges): AF-AFP if gestational age 13W0D—36W6D with 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: 40 mg in sterile media. Smaller samples always accepted but may require additional culture time. **NO** formalin or freezing.

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