HEART INSTITUTE DIAGNOSTIC LABORATORY- PRENATAL SAMPLE REQUISITION

(Must be completed in addition to the individual Test Requisition)

Patient label	Cincinnati Children's Hospital Medical Center 240 Albert Sabin Way, Room S4.381 Cincinnati, OH 45229-3039 Phone: 513-803-1751 Fax: 513-803-1748

PATIENT INFORMATION

First Name_____ MI _____ Last Name_____

DOB _____ Street Address _____

City, State, Zip Code _____

Fetal Specimen type: (MM/DD/YYYY)

☐ Amniotic Fluid ☐ Chorionic Villi ☐ Cultured Cells Date Collected _____
☐ Other_____

Maternal Specimen type: (MM/DD/YYYY)

☐ Blood ☐ Buccal swab (X2) ☐ Other _____ Date Collected _____

SAMPLE REQUIREMENTS

AMNIOTIC FLUID	**Chorionic Villi**
Amniotic Fluid – 20mL Maternal sample – 3mL blood in EDTA Lavender top tube OR 2 buccal swabs	Chorionic Villi – 30+mg Maternal sample – 3mL blood in EDTA Lavender top tube OR 2 buccal swabs

TEST TO BE PERFORMED

GENE TEST TO BE PERFORMED_____
(Individual gene test requisition must be included)
Is this a known mutation – Yes / No If yes, what is the known mutation_____

☐ Amniotic Fluid (Requires cell culture and maternal cell contamination studies)
☐ Chorionic Villi (Requires cell culture and maternal cell contamination studies)
☐ Cultured cells (Requires maternal cell contamination studies)

Ordering Physician's signature_____Date_____ (Required)

Please note:

- Call Amy Shikany, Genetic Counselor for the Heart Institute Diagnostic Lab, at 513-803-3317 before sending prenatal samples
- Turnaround time is estimated to be 4-6 weeks. Prenatal samples are given priority
- The Heart Institute Diagnostic Lab does not accept samples on the weekends or holidays
- If you are sending prenatal cells in culture, make sure that your institution keeps a back up culture

ONE OF THE FOLLOWING BILLING OPTIONS MUST BE INDICATED.

The Patient Pay option must include payment with the sample.
The Direct Insurance Billing option must include a copy of the insurance card with the requisition.

☐ **Referring Facility**_____

Bill to name_____ and/or Department_____

Facility address_____

Contact name _____ Phone number_____

Institution code _____ Fax number_____

☐ **Patient Pay** ☐ Credit card ☐ Check

Name (as it appears on credit card)_____ Expiration Date _____

Credit Card Type ☐ Visa ☐ Mastercard ☐ Other _____

Credit Card Number _____ 3 Digit Security Code _____

☐ **Insurance Company***_____

Subscriber ID: _____ Group Name/Number:_____

Subscriber Name, Address and Phone number: _____

_____

Ordering Physician Name and NPI #: _____

Diagnosis Code(s):_____

*Please note, Cincinnati Children's Hospital Medical Center cannot bill out of state Medicaid.