THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

GENETICS LABORATORY
CYTOGENETICS REQUISITION FORM

Ship To: O'Donoghue Research Bldg.
1122 NE 13 Street, Suite 1400
Oklahoma City, OK 73104
Phone: 405-271-3589
Fax: 405-271-7117
After hours phone: 405-496-9514

Courier Service in OKC metro area call Rapid Transit 793-1122 for specimen pickup

PLEASE COMPLETE ALL FORMS AND SEND WITH PATIENT SAMPLE

REFERRING PHYSICIAN/FACILITY

Physician Name_____

NPI_____

Phone(____)_____ Fax (___)_____

Genetic Counselor _____ Phone(___)_____

Laboratory/Institution_____

Address_____

City_____ State_____ Zip_____

Phone(____)_____ Fax (___)_____

PATIENT AND BILLING INFORMATION

Patient Name (last,first,m.)_____

Parent Name (if patient is a minor)_____

DOB_____ SSN_____ MRN_____

Sex: □ Male □ Female □ Ambiguous □ Unknown □ Inpatient □ Outpatient

Ethnicity of patient (check all that apply)
□ African-American □ Asian □Caucasian/NW European □ E. Indian
□ Hispanic □ Jewish-Ashkenazi □ Jewish-Sephardic □ Native American
□ Native Hawaiian/Other Pacific Islander □ Other_____

Patient's Address_____

City_____ State_____ Zip Code_____

SPECIMEN/CLINICAL INFORMATION

Diagnosis/Clinical Findings/Family History _____

You may also list ICD-10 codes

Date Specimen Collected_____ Time_____

SPECIMEN TYPES & COLLECTION REQUIREMENTS

□ **Peripheral Blood** □ **Cord Blood** □ **Pellet** previous lab # _____
3-5 cc in large sodium heparin tube (dark green top), mix well. Keep specimen at room temperature or cooler, do not freeze. No additional blood needed for FISH

□ **Amniotic Fluid** □ **CVS** □ **Fetal Urine**
DO NOT TRANSPORT SPECIMENS IN SYRINGES!
Collect 15-20 cc and transfer to sterile centrifuge tubes. For FISH studies an additional 5 cc of fluid is required. Keep specimen cool but do not freeze.
Gestational age by: ultrasound_____ or LMP_____
Gravida__ __ Para__ __ __ __

□ **Skin Biopsy** □ **Products of Conception** □ **Placenta** □ **Fetal Tissue**
2-3 cc/1-2cm2 in transport media or sterile normal saline. Do not use formalin and do not use a fixative. Observe sterile technique. Keep cool, do not freeze

□ **Unstained Slides (FISH testing only)**

□ **Buccal swab (FISH testing only)** Collect 2 specimens w/nylon brushes. Keep fresh sample at room temperature.

TEST INFORMATION

Test Type

□ **Karyotype** (routine chromosome analysis)

□ **Karyotype and FISH Select a FISH probe**

□ **FISH only Select a FISH probe** If previous chromosome studies have been done. provide a copy of these results if performed at another lab.

□ **Culture only** _____

FISH Probes

□ Trisomy of _____
□ Screen for trisomies of 13, 18, 21, X and Y
□ 1p36 deletion syndrome
□ Angelman syndrome
□ Cri-du-Chat syndrome
□ Kallmann syndrome
□ Miller-Dieker syndrome
□ Smith-Magenis syndrome
□ Sotos syndrome
□ Turner syndrome
□ Wolf-Hirschorn syndrome
□ CHARGE syndrome
□ DiGeorge syndrome 22q11.2
□ Klinefelter syndrome
□ Prader-Willi syndrome
□ Sex chromosomes
□ SRY gene deletion
□ Williams syndrome

* **If you would like to order a molecular, sequencing, or cancer test please refer to the correct requisition forms. This is not the correct form to order those tests.**

ADDITIONAL REPORT

Physician/Facility_____

Phone_(___)_____ Fax_(___)_____

Address_____

_____

GENETICS LABORATORY USE ONLY

Laboratory Number_____

Date & Time of Pick-Up/Delivery_____

Location_____

Initials_____ Check-in_____

Additional Specimen(s) sent for this patient_____

Previous Lab Number_____

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

Genetics Laboratory
Billing Information Form

Patient Name LAST_____ FIRST_____ MI_____

YOU MUST CHOOSE ONE OF THE THREE BILLING OPTIONS LISTED BELOW.
PLEASE FORWARD ALL BILLING QUESTIONS TO DANIELLE OTIS AT DOTIS@OUHSC.EDU OR CALL 405-271-3589 OPT 4
AT THIS TIME WE DO NOT ACCEPT OUT-OF-STATE MEDICAID

PAYMENT OPTION 1-INSTITUTION

INSTITUTION NAME _____

BILLING ADDRESS_____

CITY, STATE, ZIP _____ CONTACT NAME_____

PHONE NUMBER_____ FAX NUMBER_____ CONTACT EMAIL ADDRESS _____

PAYMENT OPTION 2-SELF PAY (PAYMENT MUST BE SENT WITH SAMPLE)

☐ **CREDIT CARD** (CIRCLE ONE) AMEX DISCOVER VISA MASTERCARD AMOUNT TO CHARGE_____

VALID CARD # _____ EXP DATE_____

CVV CODE _____ CARDHOLDER PRINTED NAME_____

BILLING ADDRESS _____ CITY, STATE, ZIP_____

CARDHOLDER SIGNATURE _____

☐ **CHECK #** _____ AMOUNT ENCLOSED_____

PAYMENT OPTION 3-INSURANCE PROVIDE A LEGIBLE COPY OF THE FRONT & BACK OF INSURANCE CARD
PLEASE NOTE: OUR FACILITY WILL CONFIRM COVERAGE AND VERIFY WHETHER OR NOT THE TEST(S) ORDERED ARE COVERED BY YOUR PLAN.
OUR OFFICE CAN ALSO OBTAIN PRE-AUTHORIZATION FROM THE INSURANCE PLAN.

PRIMARY INSURANCE POLICYHOLDER NAME _____ POLICYHOLDER DOB_____

PRIMARY POLICYHOLDER SS# _____ GENDER:○M ○F EMPLOYER_____

RELATIONSHIP TO PATIENT_____ POLICY # _____

GROUP #_____ INSURANCE CO. NAME _____

PHONE _____ CLAIMS ADDRESS _____

CITY, STATE, ZIP_____ INSURANCE AUTH #_____

SECONDARY INSURANCE POLICYHOLDER NAME _____ POLICYHOLDER DOB_____

SECONDARY POLICYHOLDER SS# _____ GENDER:○ M ⊙ F EMPLOYER_____

RELATIONSHIP TO PATIENT_____ POLICY # _____

GROUP #_____ INSURANCE CO. NAME _____

PHONE _____ CLAIMS ADDRESS _____

CITY, STATE, ZIP_____ INSURANCE AUTH #_____

I CONSENT TO HAVE THE TEST(S) LISTED ON THE PREVIOUS PAGE PERFORMED. I AUTHORIZE THE UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY TO FURNISH ANY MEDICAL INFORMATION REQUESTED ON MYSELF, OR MY COVERED DEPENDENTS. IN CONSIDERATION OF SERVICES RENDERED, I TRANSFER AND ASSIGN ANY BENEFITS OF INSURANCE TO UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY. I UNDERSTAND I AM RESPONSIBLE FOR ANY CO-PAY, DEDUCTIBLES, OR NON-AUTHORIZED SERVICES AND REMAINING BALANCES AFTER INSURANCE REIMBURSEMENT. I UNDERSTAND I AM FULLY RESPONSIBLE FOR PAYMENT OF MY ACCOUNT IF THE UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY IS NOT A PARTICIPANT WITH MY HEALTH PLAN OR MY HEALTH PLAN DOES NOT FULLY REIMBURSE MY MEDICAL SERVICES DUE TO LACK OF AUTHORIZATION OR MEDICAL NECESSITY.

PRINTED NAME _____ SIGNATURE_____ DATE _____