GENETICS ASSOCIATES INCORPORATED
www.geneticsassociates.com

PRENATAL REQUISITION FORM

1916 Patterson Street, Suite 400
Nashville, Tennessee 37203
Phone: 615-327-4532
Fax: 615-327-0464

PATIENT INFORMATION

Name: *(Last, First, Middle)*	□ Male □ Female □ Unknown Date of Birth: / /
Address:	Home Phone: Work Phone:
City: State: Zip:	Lab # Hospital #

REFERRED BY

Physician: *(print)*	Facility: Phone:
I attest that this patient has been informed and has given consent for the test(s) I have ordered under applicable law.	Address:
Physician/Authorized Signature: _____	City: State: Zip:

BILLING

□ **CLIENT BILL** * □ **INSURANCE** *□ **MEDICARE/MEDICAID** □ **SELF-PAY** **** Attach billing information***

SPECIMEN INFORMATION *(DO NOT FREEZE - ALL SPECIMENS MUST BE LABELED)*

Date of Collection: ____/____/____ Time of Collection:_____ am / pm

Gestational Age: _____ LMP: _____ EDD: _____

History: G____P____A____ Number of fetuses: _____

Weight: _____ Race: _____ Diabetic: □ Yes □ No

Fetal sex, as determined by Ultrasound, if known □ Male □ Female

□ Amniotic Fluid
□ Chorionic Villi
□ Products of Conception (POC) □ Villi □ Placenta □ Other: _____
□ Tissue, source: _____
□ Parental Peripheral Blood
□ Cord Blood
□ □ Paraffin Slides – ***Positively charged 3-4µ thick (2 slides per probe minimum)***
□ Other:_____

REFERRING DIAGNOSES *(CHECK ALL THAT APPLY)*

ICD-10: _____

□ Advanced Maternal Age
□ Abnormal Maternal Serum screen, increased risk of:
□ Trisomy 18 □ Trisomy 21
□ Fetal Demise
□ Missed Abortion
□ Spontaneous Abortion
□ Recurrent Pregnancy Loss
□ Trisomy: _____

□ Ultrasound Abnormalities:
_____
_____
□ Family History of:
_____
□ Other:
_____
_____

REQUESTED TESTING

□ If a verbal preliminary result is desired, please check box and provide contact name and number below. Failure to do so may result in delay of preliminary results.

_____

□ Chromosome Analysis *(karyotype)*

□ If normal chromosomes; perform
SNP Microarray (ARRAYnet)*SNP*
Insurance Preauthorization Code: _____ **(Required)**

□ **SNP Microarray (ARRAYnet)*SNP***

□ **Culture Only**

□ **Retain for additional testing**

FISH PANELS

□ AneuVysion® (includes X,Y,13,18,21)
□ POC FISH (X,Y,13,15,16,18,21,22)
□ POC ICP (ICPnet)
□ If normal ICP FISH; perform
SNP Microarray (ARRAYnet)*SNP*

FISH for Microdeletion Syndromes:

□ Angelman (15q12)
□ Cri-du-Chat (5p15.3)
□ DiGeorge (22q11.2)
□ DiGeorge II (10p14)
□ Kallman (Xp22.3)
□ Miller-Dieker (17p13.3)
□ Pallister-Killian/Tetrasomy 12p
□ Phelan-McDermid (22q13)
□ Prader-Willi (15q12)
□ Saethre-Chotzen (7p21.1)
□ Smith-Magenis (17p11.2)
□ Sotos (5q35.3)
□ Steroid Sulfatase Deficiency (Xp22.3)
□ Williams (7q11.23)
□ Wolf-Hirschhorn (4p16.3)
□ 1p36 microdeletion
□ Other:
_____

FISH for Sex Chromosome Abnormalities:

□ Sex Determination *(X/SRY)*
□Turner Syndrome *(CEPX/CEPY)*

□ Other: _____

Molecular: (PCR)*(Submit in EDTA Purple-top tube)*
Thrombophilia Profile (THROMBOnet)
□ Factor II (Prothrombin)
□ Factor V Leiden
□ MTHFR

ADDITIONAL TESTING:

(Parental Blood in EDTA tube may be required for carrier testing)
□ Cystic Fibrosis
□ Fragile X
□ AZF – *Y Microdeletion*
□ Osteogenesis Imperfecta – Collagen Testing
□ Spinal Muscular Atrophy
□ Other: _____
(Provide documentation of prior family studies)

SPECIMEN COLLECTION

Test	Specimen Type	Volume	Container	Storage Conditions	Special Instructions
Chromosome Analysis & FISH	Amniotic Fluid	16-20 mL of whole fluid	Sterile Centrifuge Tube	Room Temperature	**Do Not Freeze**
	Chorionic Villi	>10 mg of Villi	Sterile Centrifuge Tube with Transport Media (RPMI)	Room Temperature	**Do Not Freeze**
	Paraffin-embedded Tissue	**Positively charged 3-4µ thick, 2 slides per probe minimum**	Slide Mailer	Room Temperature	
	Peripheral Blood	Adult/Child: 2-5 mL Newborn: 1-2 mL PUBS: 1-2 mL	Sodium Heparin Green-top Tube	Room Temperature or Refrigerate	**Do Not Freeze**
	Products of Conception	>10 mg of Villi, Placenta, Placental Membrane, or Fetal Tissue	Sterile Specimen Cup or Centrifuge Tube with Sterile Saline or Transport Media (RPMI)	Room Temperature or Refrigerate	**Do Not Freeze** **Do Not Add Formalin**
	Tissue Biopsy	$3mm^3$	Sterile Specimen Cup or Centrifuge Tube with Sterile Saline or Transport Media (RPMI)	Room Temperature or Refrigerate	**Do Not Freeze** **Do Not Add Formalin**
SNP Microarray	Amniotic Fluid	10 mL of additional whole fluid	Sterile Centrifuge Tube	Room Temperature	**Do Not Freeze**
	Chorionic Villi	>10 mg of additional Villi	Sterile Centrifuge Tube With Transport Media	Room Temperature	**Do Not Freeze**
	Peripheral Blood	Adult/Child: 2-5 mL Newborn: 1-2 mL PUBS: 1-2 mL	EDTA (Sodium Heparin acceptable)	Room Temperature or Refrigerate	**Do Not Freeze**
	Products of Conception	>10 mg of Villi, Placenta, Placental Membrane, or Fetal Tissue	Sterile Specimen Cup or Centrifuge Tube with Sterile Saline or Transport Media (RPMI)	Room Temperature or Refrigerate	**Do Not Freeze** **Do Not Add Formalin**

SPECIMEN COLLECTION AND TRANSPORTATION

- Clearly label each specimen with patient name and one other unique identifier such as date of birth or medical record number.
- Call Genetics Associates, Inc. at 615-327-4532 for pick-up in the greater Nashville area.
- Federal Express overnight shipment will be provided for all outlying areas.
- Whenever there is a sample to be shipped on Friday, please be sure to mark the **"Saturday Delivery"** box on the FedEx air bill.
- Please send samples with a cool pack to ensure specimen integrity.
- **Please refer to the Genetics Associates website for complete specimen collection guide. www.geneticsassociates.com**

PATIENT AUTHORIZATION

I understand that I am responsible for understanding information about my health insurance policy and providing such information to Genetic Associates, Inc. I understand that Genetic Associates, Inc. will be providing services and billing my insurance company but that ultimately I am responsible for all payment relating to any and all charges relating to treatment and services. I authorize Genetics Associates Inc. to obtain and release relevant medical and other information and to directly bill and submit claims to Medicare, Medicaid, Medicare Supplemental and/or other insurance providers for laboratory/medical services that Genetic Associates, Inc. provides to me. I assign insurance benefits to Genetic Associate, Inc. and acknowledge that charges that are not covered by insurance, including any applicable co-payments and deductibles, are my responsibility and I agree to pay for such charges promptly.

Signature of Patient /Responsible Party **(Required)** _____ Date **(Required)** _____

USE OF SPECIMENS

Genetics Associates Inc. may retain patient samples (specimens) for validation, educational purposes and/or research. All patient information is maintained as confidential and secure. Any patient samples which are retained by Genetics Associates, Inc. are de-identified and all individually identifiable patient information is removed before samples are used for research.

By marking the box below, you may decline research use and it will not impact the services to you by Genetic Associates, Inc. diagnostic testing/reports. Unless you mark the box below, you consent to the use of your de-identified patient sample for the limited purposes described above.

□ I am checking this box to indicate that the sample may **NOT** be used for validation, educational purposes and/or research. Patient initials: _____

My Address is _____

My Telephone Number is _____ My email address is _____

Signature of Patient /Responsible Party **(Required)** _____ Date **(Required)** _____

_____

Relationship to Patient **(Required)**