

PATIENT INFORMATION			
Name: <i>(Last, First, Middle)</i>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Unknown
Address:	Date of Birth:    /    /	Home Phone:                      Work Phone:	
City:                                      State:                      Zip:	Lab #	Hospital #	
REFERRED BY			
Physician: <i>(print)</i>	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:	Fax:	
Physician/Authorized Signature: _____	City:	State:	Zip:
BILLING			
<input type="checkbox"/> CLIENT BILL	<input type="checkbox"/> INSURANCE	<i>* Attach billing information including a copy of the patient's face sheet plus a copy of the insurance card(s) for billing purposes.</i>	
<input type="checkbox"/> SELF-PAY	<input type="checkbox"/> MEDICARE/MEDICAID		
SPECIMEN INFORMATION (DO NOT FREEZE - ALL SPECIMENS MUST BE LABELED)			
Date of Collection: ___/___/___	<input type="checkbox"/> Peripheral Blood	<input type="checkbox"/> Fixed Pellet (FOR MICROARRAY ONLY)	
Time of Collection: _____	<input type="checkbox"/> Cord Blood	<input type="checkbox"/> Tissue, Source: _____	
REFERRING DIAGNOSES (CHECK ALL THAT APPLY)			
<b>ICD-10:</b> _____	<input type="checkbox"/> Failure to Thrive	<input type="checkbox"/> Confirmation Study or Follow-up study (Refer to accession #/patient name of prior study, if known)	
<input type="checkbox"/> Ambiguous Genitalia	<input type="checkbox"/> Hypotonia	_____	
<input type="checkbox"/> Autism	<input type="checkbox"/> Infertility	<input type="checkbox"/> Family History of: _____	
<input type="checkbox"/> Azoospermia	<input type="checkbox"/> Klinefelter Syndrome	_____	
<input type="checkbox"/> Cardiac anomaly	<input type="checkbox"/> MR	_____	
<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Multiple Congenital Anomalies	_____	
<input type="checkbox"/> Cystic Hygroma	<input type="checkbox"/> Recurrent Pregnancy Loss	<input type="checkbox"/> Other: <i>(please specify below)</i>	
<input type="checkbox"/> Delayed Growth	<input type="checkbox"/> Seizures	_____	
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Short Stature	_____	
<input type="checkbox"/> Dysmorphic Features	<input type="checkbox"/> Trisomy: _____	_____	
<input type="checkbox"/> Fetal Demise	<input type="checkbox"/> Turner Syndrome	_____	
REQUESTED TESTING			
<input type="checkbox"/> <b>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.</b>  _____  <input type="checkbox"/> <b>Chromosome Analysis (<i>karyotype</i>)</b>  <input type="checkbox"/> <b>If normal chromosomes; perform SNP Microarray (ARRAYnet)<sup>SNP</sup></b> Insurance Preauthorization Code: _____ <i>(Required)</i>  <input type="checkbox"/> <b>SNP Microarray (ARRAYnet)<sup>SNP</sup></b> Insurance Preauthorization Code: _____ <i>(Required)</i>  <input type="checkbox"/> <b>Culture Only</b>  <b>FISH for Sex Chromosome Abnormalities:</b> <input type="checkbox"/> Sex Determination ( <i>X/SRY</i> ) <input type="checkbox"/> Turner Syndrome ( <i>CEPX/CEPY</i> )	<b>FISH for Microdeletion Syndromes:</b> <input type="checkbox"/> Angelman (15q12) <input type="checkbox"/> Cri-du-Chat (5p15.3) <input type="checkbox"/> DiGeorge (22q11.2) <input type="checkbox"/> DiGeorge II (10p14) <input type="checkbox"/> Kallman (Xp22.3) <input type="checkbox"/> 1p36 microdeletion <input type="checkbox"/> Miller-Dieker (17p13.3) <input type="checkbox"/> Pallister-Killian/Tetrasomy 12p <input type="checkbox"/> Phelan-McDermid (22q13) <input type="checkbox"/> Prader-Willi (15q12) <input type="checkbox"/> Saethre-Chotzen (7p21.1) <input type="checkbox"/> Smith-Magenis (17p11.2) <input type="checkbox"/> Sotos (5q35.3) <input type="checkbox"/> Steroid Sulfatase Deficiency (Xp22.3) <input type="checkbox"/> Williams (7q11.23) <input type="checkbox"/> Wolf-Hirschhorn (4p16.3) <input type="checkbox"/> Other: _____  <b>Other FISH:</b> <input type="checkbox"/> Trisomy 13 - Patau Syndrome <input type="checkbox"/> Trisomy 18 - Edwards Syndrome <input type="checkbox"/> Trisomy 21 - Down Syndrome	<b>Molecular: PCR (<i>Submit in EDTA Purple-top tube</i>)</b>  <b>Thrombophilia Profile (THROMBOnet)</b> <input type="checkbox"/> Factor II (Prothrombin) <input type="checkbox"/> Factor V Leiden <input type="checkbox"/> MTHFR  <b>ADDITIONAL SENDOUT TESTING:</b> <i>(Parental Blood in EDTA tube may be required for carrier testing)</i> <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Fragile X <input type="checkbox"/> AZF – Y Microdeletion <input type="checkbox"/> Other: _____ <i>(Provide documentation of prior family studies)</i>	

**PATIENT PREPARATION**

Refer to collection facility's procedures for patient preparation requirements.

**SPECIMEN COLLECTION**

Specimen Type	Volume	Container	Storage Conditions	Special Instructions
<b>Chromosome Analysis &amp; FISH</b>				
Amniotic Fluid	10-20 mL of whole fluid	Sterile Centrifuge Tube	Room Temperature: 20-22°C	Do Not Freeze
Chorionic Villi	10-20 mg of Villi	Sterile Centrifuge Tube with Transport Media (RPMI)	Room Temperature: 20-22°C	Do Not Freeze
Paraffin-embedded Tissue	Positively charged 3-4 μ thick, 2 slides per probe minimum	Slide Mailer	Room Temperature: 20-22°C	
Peripheral Blood	Adult: 2-5 mL Child ≥8 days: 2-5 mL Newborn: 1-2 mL PUBS: 1-2 mL	Sodium Heparin Green-top Tube  EDTA for Parental Studies	Room Temperature: 20-22°C or Refrigerated Temperature: 2-8°C	Do Not Freeze Invert Tube 4-8 Times to prevent clots
Products of Conception	15-20 mg of Villi, Placenta, Placental Membrane, or Fetal Tissue	Sterile Specimen Cup or Centrifuge Tube with Sterile Saline or Transport Media (RPMI)	Room Temperature: 20-22°C or Refrigerated Temperature: 2-8°C	Do Not Freeze Do Not Add Formalin
Solid Tissue Biopsy	3mm³	Sterile Specimen Cup or Centrifuge Tube with Sterile Saline or Transport Media (RPMI)	Room Temperature: 20-22°C or Refrigerated Temperature: 2-8°C	Do Not Freeze Do Not Add Formalin

**SNP Microarray**

Amniotic Fluid	10 mL of additional whole fluid	Sterile Centrifuge Tube	Room Temperature: 20-22°C	Do Not Freeze
Chorionic Villi	>10 mg of additional Villi	Sterile Centrifuge Tube with Transport Media	Room Temperature: 20-22°C	Do Not Freeze
Fixed Pellets	Pellet must be visible	Sterile Centrifuge Tube With 3:1, Methanol : Acetic Acid	Refrigerated Temperature: 2-8°C	Pellet should not be older than 1 week
Peripheral Blood	Adult: 2-5 mL Child ≥8 days: 2-5 mL Newborn: 1-2 mL	EDTA Tube	Room Temperature: 20-22°C or Refrigerated Temperature: 2-8°C	Do Not Freeze Invert Tube 4-8 Times to prevent clots
Products of Conception	>10 mg of additional Villi, Placenta, Placental Membrane, or Fetal Tissue	Sterile Specimen Cup or Centrifuge Tube with Sterile Saline or Transport Media (RPMI)	Room Temperature: 20-22°C or Refrigerated Temperature: 2-8°C	Do Not Freeze Do Not Add Formalin

**Molecular (PCR)**

Peripheral Blood	Adult: 2-5 mL Child ≥8 days: 2-5 mL Newborn: 1-2 mL	EDTA Tube	Room Temperature: 20-22°C or Refrigerated Temperature: 2-8°C	Do Not Freeze Invert Tube 4-8 Times to prevent clots
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**Isolated or Extracted Nucleic Acid Acceptance Policy:** Genetics Associates, Inc. only accepts nucleic acid for clinical testing that was isolated or extracted in a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by the CAP and/or the CMS.

**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.
- Mark the "Saturday Delivery" box on the FedEx air bill for all samples shipped on Friday.
- Send samples with a cold pack during warmer weather to ensure specimen integrity. (Use frozen cold pack for specimens requesting PCR)
- Refer to the Genetics Associates website for complete specimen collection guide. [www.geneticsassociates.com](http://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) \_\_\_\_\_