GENETICS ASSOCIATES INCORPORATED

www.geneticsassociates.com

CONSTITUTIONAL 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: Fax:
I attest that this patient has been informed and has given consent for the test(s) I have ordered under applicable law. Informed consent (Form FC 012.01) is required for specimens collected in State of New York. Physician/Authorized Signature: ___________________________________	Address:
	City: State: Zip:

BILLING

□ **CLIENT BILL** □ **INSURANCE***
□ **SELF-PAY** □ **MEDICARE/MEDICAID***

**** Attach billing information including a copy of the patient's face sheet plus a copy of the insurance card(s) for billing purposes.***

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

Date of Collection: ____/____/____

Time of Collection:_____________

□ Peripheral Blood □ Fixed Pellet (FOR MICROARRAY ONLY)
□ Cord Blood
□ Tissue, Source:________________

REFERRING DIAGNOSES *(CHECK ALL THAT APPLY)*

ICD-10: ___________

□ Ambiguous Genitalia
□ Autism
□ Azoospermia
□ Cardiac anomaly
□ Congenital Heart Defect
□ Cystic Hygroma
□ Delayed Growth
□ Developmental Delay
□ Dysmorphic Features
□ Fetal Demise

□ Failure to Thrive
□ Hypotonia
□ Infertility
□ Klinefelter Syndrome
□ MR
□ Multiple Congenital Anomalies
□ Recurrent Pregnancy Loss
□ Seizures
□ Short Stature
□ Trisomy: __________
□ Turner Syndrome

□ Confirmation Study or Follow-up study
(Refer to accession #/patient name of prior study, if known)
____

□ 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** *(Standard/ 20 cells)*
□ **Chromosome Analysis** *(Mosaicism/ 50 cells)*

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

□ **SNP Microarray (ARRAYnet)*SNP*****
Insurance Preauthorization Code: _________ ***(Required)***

□ **Culture Only**

FISH for Sex Chromosome Abnormalities:
□ Genotypic Sex Determination *(CEPX/SRY)*
(15 metaphase cell analysis)

□ Turner Syndrome/Mosaicism *(CEPX/CEPY)*
(200 interphase cell analysis)

FISH for Microdeletion Syndromes:
□ Angelman (15q12)
□ Cri-du-Chat (5p15.3)
□ DiGeorge (22q11.2)
□ DiGeorge II (10p14)
□ Kallman (Xp22.3)
□ 1p36 microdeletion
□ 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)
□ Other: __________________________

Other FISH:
□ Aneuploidy Screen (X,Y,13,18,21)
□ Trisomy 13 - Patau Syndrome
□ Trisomy 18 - Edwards Syndrome
□ Trisomy 21 - Down Syndrome

Molecular: PCR** ***(Submit in EDTA Purple-top tube)***

Thrombophilia Profile (THROMBOnet)
□ Factor II (Prothrombin)
□ Factor V Leiden
□ MTHFR

ADDITIONAL SENDOUT TESTING:
(Parental Blood in EDTA tube may be required for carrier testing)

□ Cystic Fibrosis
□ Fragile X
□ AZF – *Y Microdeletion*
□ Other: ______________________________
(Provide documentation of prior family studies)

PATIENT PREPARATION

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

SPECIMEN COLLECTION

Specimen Type	Volume	Container	Storage Conditions	Special Instructions
Chromosome Analysis & FISH				
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	$3mm^3$	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

** **SNP Microarray and PCR testing** are not available on specimens originating in New York State.

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**

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), with the exception of samples collected in the State of New York, for test development and improvement, internal validation, quality assurance, and training purposes. All patient information is maintained as confidential and secure. All patient samples which are retained by Genetics Associates, Inc. are de-identified and all individually identifiable patient information is removed before samples are used.

Declining the use of remaining samples for test development and improvement, internal validation, quality assurance, and training purposes will not impact the services to you by Genetics Associates, Inc. diagnostic testing/reports.

If the box below is not checked, 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.

Specimens Collected in the State of New York

□ I m a New York state resident, and by checking this box, I give permission for GAI to retain any remaining sample longer than 60 days after the completion of testing, and to be used as a de-identified sample for test development and improvement, internal validation, quality assurance, and training purposes.

Signature of Patient /Authorized Representative **(Required)** ____ Date **(Required)** ____________________