Genetics Associates, LLC
A Division of Sonic Healthcare USA

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www.geneticsassociates.com

PRENATAL REQUISITION FORM

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. 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:_____ 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****
Insurance Preauthorization Code: _____ **(Required)**

□ **SNP Microarray****

□ **Culture Only**

□ **Retain for additional testing**

FISH PANELS

□ Aneuploidy Screening (includes CEP X, CEPY, 13, 18, 21) (200 interphase cell analysis)
□ POC FISH (CEPX, CEPY, 13, 15, 16, 18, 21, 22)

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 *(CEPX/SRY)*
(Genotypic sex determination; 15 metaphase cell analysis)
□ Turner Syndrome *(CEPX/CEPY)*
(Turner syndrome/mosaicism; 200 interphase cell analysis)

□ Other: _____

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 Refrigerated: 2-8°C if overnight	Do not freeze
Chorionic Villi	10-20 mg of villi	Sterile centrifuge tube with sterile saline or RPMI	Room temperature: 20-22°C	Do not freeze
Paraffin-embedded Tissue	Positively charged 3-4µ thick, 2 slides per probe minimum	Plastic slide transport box	Room temperature: 20-22°C	Include H&E slide with area of interest marked
Peripheral Blood	Adult: 2-5 mL Child ≥8 days: 2-5 mL Newborn: 1-2 mL PUBS: 1-2 mL	Sodium heparin tube EDTA tube for parental studies	Room temperature: 20-22°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 container with sterile saline or RPMI	Refrigerated: 2-8°C	Do not freeze Do not add Formalin
Skin/Tissue Biopsy	3mm³	Sterile centrifuge tube with sterile saline or RPMI	Room temperature: 20-22°C or Refrigerated: 2-8°C if overnight	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 sterile saline or RPMI	Room temperature: 20-22°C	Do not freeze
Peripheral Blood	Adult: 2-5 mL Child ≥8 days: 2-5 mL Newborn: 1-2 mL PUBS: 1-2 mL	EDTA tube preferred, sodium heparin acceptable	Room temperature: 20-22°C or Refrigerated: 2-8°C	Do not freeze Invert tube 4-8 times to prevent clot
Products of Conception	>10 mg of additional villi, placenta, placental membrane, or fetal tissue	Sterile centrifuge tube with sterile saline or RPMI	Room temperature: 20-22°C or Refrigerated: 2-8°C	Do not freeze Do not add Formalin
Molecular (PCR)				
Peripheral Blood	Adult: 2-5 mL	EDTA tube preferred; sodium heparin acceptable	Room temperature: 20-22°C or Refrigerated: 2-8°C	Do not freeze Invert tube 4-8 times

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

Isolated or Extracted Nucleic Acid Acceptance Policy: Genetics Associates, LLC 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, LLC 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, LLC 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, LLC 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, LLC 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 am 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)** _____