GENETICS ASSOCIATES

PRODUCTS OF CONCEPTION REQUISITION FORM

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

PATIENT INFORMATION

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

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 the state of New York. Physician/Authorized Signature: _____	Address: City: State: Zip:

BILLING

□ **CLIENT BILL** □ **INSURANCE *** **** Attach billing information including a copy of the patient's face sheet plus a copy of the insurance card(s) for billing purposes.***
□ **SELF-PAY** □ **MEDICARE MEDICAID ***

SPECIMEN INFORMATION

Date of Collection: ____/____/____ Time of Collection: _____ am / pm History: G____P____A____ Number of fetuses: _____ **ICD-10:** _____
Gestational Age: _____ LMP: _____ EDD: _____
Reason for Referral:_____

REQUESTED TESTING

□ **Chromosome Analysis** *(karyotype)*
□ **If Normal: Perform SNP Microarray****
□ **If Failure/No Growth: Reflex to SNP Microarray****
□ **SNP Microarray****
□ **POC FISH** (X, Y, 13, 15, 16, 18, 21, 22)
Other: _____

PATIENT PREPARATION

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

SPECIMEN COLLECTION/TRANSPORTATION

Volume	Container	Storage Conditions	Special Instructions
15-20 mg of villi, placenta, placental membrane, or fetal tissue (Additional 10 mg if Microarray is ordered)	Sterile container with sterile saline or RPMI	Refrigerated Temperature: 2-8°C	**DO NOT FREEZE** **DO NOT ADD FORMALIN**

****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.

- 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 warm 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 Genetics Associates, LLC. I understand that Genetics Associates, LLC 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 Genetics Associates, LLC provides to me. I assign insurance benefits to Genetics Associates, LLC 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)** _____