GENETICS LABORATORY OUTPATIENT - ORDER FORM

Central Scheduling
PH:937-641-4000 Fax: 937:641-4500
One Children's Plaza • Dayton, OH 45404-1815 • childrensdayton.org

ALL INFORMATION ON THIS FORM IS CONFIDENTIAL. ALL INFORMATION IS REQUIRED

PATIENT NAME (LAST, FIRST, MI)	ORDERING PROVIDER	OFFICE PHONE NUMBER
Address	Home Phone	
City State Zip	Work Phone Cell Phone	
Preferred Contact Phone ☐ Work ☐ Cell ☐ Home	Email Address	
Sex Date of Birth	Medical Record #	
Specimen Collection: Fax to: Call to: Copy to:	Date: Time: Tech:	

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other - please specify:

Clinical Description or ICD10 code (required):

ABN has been obtained and sent to the hospital.

Physician or Authorized Signature: _____ Date: _____

☐ STAT ☐ ASAP

CYTOGENETICS (Test Code) Phone 937-641-3801 • Fax 937-641-5956

2-3 cc blood in Na-Heparin tube (green top or as indicated

☐ **Standard Chromosome Analysis (FOR ANEUPLOIDY SCREEN - R/O TURNER, DOWN SYND, ETC) (CHROB)**

☐ **High Resolution Peripheral Blood Lymphocyte Chromosome Analysis FOR DEVELOPEMENTAL DELAY, DYSMORPHISM, ETC (CHROB)**

☐ **Microarray Comparative Genomic Hybridization FOR IN-DEPTH INVESTIGATION OF AUTISM, DEV DELAY , ETC (MACGHB)**
*unless previously completed, high resolution chromosome analysis must also be ordered, above

☐ **Standard Chromosome Analysis w/ Reflex to Microarray Comparative Genome Hybridization (CHROBX)**
***Requires 3 cc peripheral blood in EDTA plus 2-3 cc peripheral blood in Na-Heparin tubes*

☐ **Parental Studies Microarray CGH/FISH (PARMCR) CHILD'S NAME:** _____
***Requires 3 cc peripheral blood in EDTA plus 2-3 cc peripheral blood in Na-Heparin tubes*

☐ **Bone Marrow Chromosome Analysis** (oncology specimens) **(BMMG)** (3 cc bone marrow)

☐ **Leukemic Blood Chromosome Analysis** (aka "blood as bone marrow") **(BMMG)** (5-7 cc peripheral blood)

☐ **Fluorescence in *situ* hybridization** (Specify below)

- ☐ Velocardiofacial / DiGeorge Syndrome: 22q11.2 **(FISHMD)**
- ☐ Williams Syndrome: 7q11.23 **(FISHMD)**
- ☐ PWS-AS 15q11.2 (for confirmation of positive DNA results ONLY) **(FISHMD)**
- ☐ Special FISH analysis **(FMISC):** _____
- ☐ Miller-Dieker Syndrome: 17p13.3 **(FISHMD)**
- ☐ Smith-Magenis Syndrome: 17p11.2 **(FISHMD)**
- ☐ XY **(XYFISH)**
- ☐ bcr-abl **(BCRFSH)**

Call Laboratory to Arrange prior to order at 937-641-3801

Molecular Genetics (Test Code) Phone 937-641-3262 • Fax 937-641-5872

3 - 10 cc blood in EDTA tube (lavender top) or as indicated

- ☐ Fragile X Syndrome **(FX)**
- ☐ Angelman Syndrome **(ANGEL)**
- ☐ Prader-Willi Syndrome **(PRW)**
- ☐ Hereditary Hemochromatosis C282Y/H63D **(HHC)**
- ☐ Spinal Muscular Atrophy **(SMAY)**
- ☐ DNA Isolation Only **(DNAI)**
- ☐ Factor V Leiden R506Q **(5FLE)**
- ☐ Prothrombin G20210A **(PRT)**
- ☐ MTHFR C677T and A1298C **(MTHFRB)**
- ☐ Thrombophilia Panel **(THROM)** - includes 5FLE, PRT, MTHFR
- ☐ Cystic Fibrosis Mutation Screening Panel **(CFMSP)**
  - ☐ with reflex to sequencing **(CFMSPR)**

Biochemical Genetics (Test Code) Phone 937-641-3262 • Fax 937-641-5872

Requires special handling and completed clinical data form. Please call the biochemical lab to schedule.

- ☐ Amino Acid Analysis, plasma (AAPP)
- ☐ Phenylalanine level, plasma (GPKU)

☐ **Other:** Please indicate test name and test code or GMISC1 (DNA test) or GMISCB (biochemical test) if known. Please indicate specimen type, tube type, and volume if known.

BILLING:
Insurance Billing - Attach demographic and insurance information Institutional Billing