Genetics Laboratory Outpatient - Order Form

Central Scheduling
PH:937-641-4000 Fax: 937:641-4500
One Children's Plaza • Dayton, OH 45404 937-641-5100, FAX 641-5403

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

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

Clinical Description (required):

ICD10 Code (Required for DCH Billing):

NOTICE TO PHYSICIANS: Medicare, Medicaid and certain commercial insurances do not reimburse for screening or other tests that are not medically necessary to diagnose and treat the patient's current symptoms and conditions. The ordering physician certifies that the following test(s) meet relevant medical necessity criteria or have been identified as screening. Advance Beneficiary Notices (ABNs) must be obtained for non-covered tests. 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**

☐ **Routine Chromosome Analysis (CHROB1)**
** Requires 1 cc peripheral blood in Na-Heparin tube

☐ **Chromosome Analysis, Turner syndrome (TURNER)**
** Requires 3 cc peripheral blood in Na-Heparin tube

☐ **Chromosomal Microarray (MASNPB)**
** Requires 3 cc peripheral blood in EDTA tube

Parental Studies CHILD'S NAME: _____

☐ **Chromosomal Microarray (PARMCR)**
** Requires 3 cc peripheral blood in EDTA tube

☐ **FISH (PARF)**
** **Requires** 2-3 cc peripheral blood in Na-Heparin tube

☐ **Bone Marrow Chromosome Analysis (BMMGB)**
** Requires 3 cc bone marrow

☐ **Leukemic Blood Chromosome Analysis (BMMGB)**
** Requires 5-7 cc peripheral blood in Na-Heparin tube

Fluorescence in situ hybridization (Specify below)
** Requires 3 cc peripheral blood in Na-Heparin tube

☐ Rapid Aneuploidy FISH (13, 18, 21, X & Y) with Routine Chromosome Analysis **(RAFSH1)**
☐ Velocardiofacial/DiGeorge syndrome: 22q11.2 **(FISHMD)**
☐ Williams syndrome: 7q11.23 **(FISHMD)**
☐ Miller-Dieker syndrome: 17p13.3 **(FISHMD)**
☐ Special/Oncology FISH analysis **(FMISC):**_____
☐ Smith-Magenis syndrome: 17p11.2 **(FISHMD)**
☐ XY **(XYFSHB)**

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 peripheral blood in EDTA tube (lavendar top)**

☐ Fragile X syndrome **(FMR1)**
☐ 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)**
☐ Thrombophilia Panel **(THROM)**- includes 5FLE, PRT

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

**** 0.5 - 2 cc peripheral blood in Na-Heparin tube**

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

☐ **Other:** Please indicate test name and **test code or GMISC1 (gene 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**