Henry Ford Health System
CENTER FOR PRECISION DIAGNOSTICS

Pathology and Laboratory Medicine
Clinic Building, K6, Core Lab, E-655
2799 W. Grand Blvd.
Detroit, MI 48202
855.916.4DNA (4362)

PEDIATRIC/ADULT CYTOGENETICS REQUISITION

Required Patient Information

Name: _____ Gender: M F

MRN: _____ DOB: MM / DD / YYYY

ICD10 Code(s): _____/_____/_____

ICD-10 Codes are required for billing. When ordering tests for which reimbursement will be sought, order only those tests that are medically necessary for the diagnosis and treatment of the patient.

Ordering Physician Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

NPI:_____

Billing & Collection Information

Patient Demographic/Billing/Insurance Form is required to be submitted with this form. Most genetic testing requires insurance prior authorization. Due to high insurance deductibles and member policy benefits, patients may elect to self-pay. Call for more information (855.916.4362)

❑ Bill Client or Institution Client Name: _____ Client Code/Number: _____

❑ Bill Insurance Prior authorization or reference number: _____

❑ Patient Self-Pay Call for pricing and payment options Toll Free: 855.916.4362

Patient status at time of collection: ❑ Inpatient ❑ Outpatient Collection date: _____ Collection time: _____

Providers are responsible to obtain informed consent, as required by Michigan law, for predictive or pre-symptomatic genetic tests. Informed Consent for Genetic Testing form is available on our website. Please submit with this requisition.

Specimen/Source

❑ Peripheral blood, sodium heparin tube (10mL preferred, 3mL minimum for infants)
❑ Buccal – send brush or swab; Call lab for collection kit if needed
❑ Extracted DNA – Source:_____
(provide CLIA certificate of lab that performed the DNA extraction)
❑ Skin biopsy (send in sterile media, Ringer's lactate or saline)
❑ Other: _____

Indication for Testing

❑ Congenital anomalies/Dysmorphic features (please describe):

❑ Developmental delay/Intellectual disability
❑ Autism Spectrum Disorders
❑ Hypotonia

❑ History of pregnancy loss: Gr _____ Para _____ Ab _____
❑ Infertility
❑ Primary amenorrhea
❑ Secondary amenorrhea
❑ Family history of:

❑ Other:

Test(s) Requested

Some testing includes pathologist interpretation at a separate, additional charge.

❑ Microarray (SNP Array) (81229) *for developmental delay, congenital anomalies, autism diagnoses*
  ❑ With reflex to Chromosome Analysis if normal (see Chromosome Analysis for CPT codes)
❑ Chromosome analysis (Blood: 88230, 88262, 88291; Skin Biopsy: 88233, 88262, 88291)
  ❑ High Resolution (Chromosome analysis CPT codes + 88289)
❑ Y-Chromosome Microdeletion (81403) **(requires one EDTA and one sodium heparin tube, ≥3mL each)**
❑ Fluorescent in situ hybridization (FISH) Constitutional/Reproductive Disorder Testing (88271x3, 88275, 88273)

Individual Probes

❑ 22q11.2 DiGeorge Syndrome ❑ 5p Cri du Chat ❑ 17p11.2 Smith-Magenis ❑ X-linked Ichthyosis (STS) ❑ Yp11.3 SRY region
❑ 7q Williams Syndrome ❑ 4p16.3 Wolf-Hirschhorn ❑ 17p13.3 Lissencephaly ❑ Xp22 Kallmann Syndrome ❑ X-Y

Other Testing

Send Additional Report To

Name:

Address:

Phone #: Fax #:

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INFORMED CONSENT FOR GENETIC TESTING

PATIENT LAST NAME: (Please Print)	FIRST NAME:	MI:
DATE OF BIRTH: MM/DD/YYYY	PATIENT ID/MRN NUMBER:	

ORDERING PROVIDER INFORMATION (FULL LAST, FIRST):
Name:

Phone:

SAMPLE TYPE

- ❑ Amniotic fluid
- ❑ Blood
- ❑ Cheek swab
- ❑ Chorionic villus sample (CVS)
- ❑ Skin
- ❑ Tissue block
- ❑ Other_____

GENETIC TESTING REQUESTED FOR:

_____
(name of condition)

The intended purpose is (check all that apply):

- ❑ Carrier status
- ❑ Diagnostic
- ❑ Predictive
- ❑ Prenatal
- ❑ Pre-symptomatic
- ❑ Screening
- ❑ Other_____

1. I have been informed about the nature and the purpose of this genetic testing.
2. I have received an explanation of the effectiveness and limitations of this genetic testing.
3. I have discussed the benefits and risks of this genetic test with my physician and/or other health care professional. I understand some genetic tests can involve possible medical, psychological or insurance issues for my family and I.
4. I understand the meaning of possible test results and have been informed how I will receive the result.
5. I have been informed that genetic testing can sometimes reveal secondary findings-results that are not related to the purpose of testing. I have discussed with my health care professional if and/or how such results will be shared with me. I understand that it is up to me to decide whether I want secondary results reported back to me and what secondary results I want reported.
6. If ordered by the ordering provider above, I authorize supplemental genetic testing to further aid in diagnosis, treatment and/or risk evaluation(s).
7. I have been informed who may have access to my biological sample, and that any leftover sample may be retained by the laboratory.
8. I have been informed who may have access to my genetic test result, which is part of my confidential medical record.
9. My questions have been answered to my satisfaction.
10. I understand that this consent form is intended to be used together with the patient information booklet that contains important information explaining the above eight items. I have read this consent form and understand that I can access the booklet electronically at: https://www.michigan.gov/documents/InformedConsent_69182_7.pdf
11. I received a copy of this form for my records.

I consent to have a sample taken for genetic testing on the above-named patient for the condition(s) listed above.

_____
Signature of Patient or Authorized Designee Date

Circle one: **Self** **Parent(s)** **Legal Guardian** **Durable Power of Attorney for Health Care**

Print Name of Physician or Authorized Delegee explaining the above information:

Signature of Authorized Person: Date: