Integrated GENETICS
LabCorp Specialty Testing Group

PRENATAL CYTOGENETICS/FISH/MICROARRAY TEST REQUISITION

Highlighted fields are required.

Patient Information

Name
Last First MI

☐ Male ☐ Female Date of Birth / /

Address

Home Phone Work Phone

City State Zip

Lab # Hospital #

Client Information

I have obtained informed consent of the patient (or the patient's authorized representative) for the ordered genetic test(s) in accordance with applicable law.

Physician/Authorized Signature:

Referring Physician (print):

Genetic Counselor (print):

NPI#: Taxonomy#:

Refer to www.integratedgenetics.com to access informed consent forms for genetic testing.

Date collected: / / Date sent: / / Collected by:

Pregnancy: ☐ Yes ☐ No Egg donor used: ☐ Yes ☐ No

Date of ultrasound: / / GA on date of US: weeks days

Sex of the fetus if known: Date of LMP: / / GA by LMP: weeks days

Gestation History

of Fetuses: ☐ 1 ☐ 2 ☐ >2 (submit separate requisitions)

Gravida _____ Para _____ SAB _____ TAB _____

Specimen Type: (check one)

☐ **Amniotic Fluid** ☐ **CVS** ☐ **PUBS** ☐ **Other**_____

☐ Cord blood (specify prior to or after delivery):_____

☐ POC/Fetal Tissue (GA:_____ tissue origin:_____)

☐ POC formalin-fixed paraffin-embedded (FFPE) tissue

☐ **Parental blood for**_____

Hold cells for _____

Laboratory Test(s) Ordered (*Reflex Policy on back)

105 ☐ InSight® (FISH for 13,18,21, X and Y)
☐ If InSight is normal, reflex to Reveal® SNP Microarray-Prenatal; if InSight is abnormal, reflex to chromosome analysis

See back ☐ Chromosome analysis
477 ☐ Reflex to Reveal® SNP Microarray-Prenatal, if chromosomes are normal
478 ☐ Reflex to Reveal® SNP Microarray – POC, if POC/tissue fails to grow

See back ☐ Reveal® SNP Microarray ☐ Direct on amnio, CVS, or POC
☐ add MCC analysis to Reveal® SNP Microarray (send 1 separate tube of blood)

See back ☐ Reveal® SNP Microarray & Abbreviated Chromosome Analysis

451890 ☐ Noonan syndrome – prenatal (MCC required - send 1 separate tube of blood)

300 ☐ AF-AFP (alphafetoprotein)*

330 ☐ AChE (acetylcholinesterase)*

287 ☐ DiGeorge/VCF (FISH)

☐ Parental follow-up to Reveal® SNP Microarray (additional charges may apply)
Test code on original report: _____

☐ **Other Testing – specify (call before sending)**_____

_____

_____

Unless testing is clearly ordered as a reflex, all testing will be run concurrently when possible.

All diagnoses should be provided by the ordering physician or an authorized designee.
Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required)

ICD-CM		ICD-CM		ICD-CM	

Indication(s) for Test (check all that apply)

If ordering Reveal® SNP Microarray please submit Clinical Questionnaire

☐ Advanced maternal age (≥35) ☐ gravida 1 ☐ gravida 2+
☐ Abnormal NIPS/NIPT (include report) ☐ Abnormal maternal serum screen

Increased risk for: ☐ NTD ☐ Down Syndrome ☐ Trisomy 18
☐ Other (specify):_____

☐ Abnormal fetal ultrasound:
☐ CNS ☐ Heart ☐ Genitourinary
☐ Growth/skeletal ☐ Oligohydramnios ☐ Polyhydramnios
☐ Other/specify ultrasound finding(s): _____
_____
_____
_____

☐ Multiple SABs (Spontaneous abortion): ☐ Pregnant ☐ Not Pregnant
☐ Fetal loss/Stillbirth (POC) ☐ <20 wks ☐ >20 wks
☐ Parental chromosome analysis following abnormal prenatal results
Specify_____
☐ Confirm prenatal analysis
☐ Clarify abnormal fetal chromosomes - provide results and a copy of the karyotype
☐ Other _____

Family History

☐ Family History (include copy of report)
Specify relationship_____
☐ Chromosome abnormality (specify) _____
☐ Genetic disorders _____
☐ Autism/Autism spectrum disorders ☐ ID/DD
☐ Birth defects (specify) _____
☐ Parent(s) carrier(s) of _____
☐ Parent has chromosome rearrangement/mosaicism (specify) _____
_____
☐ Fetus at risk for _____
☐ Other _____

BILLING INFORMATION

Patient Hospital Status: ☐ Inpatient ☐ Outpatient ☐ Non-hospital

☐ Medicaid ☐ Medicare ☐ Insurance ☐ Client Bill ☐ CA XAFP ☐ Self-Pay

☐ Billing Information Attached (Please include a copy of insurance card or face sheet.)
Do not attach credit card information to this form for security purposes.

Insurance Company Name _____

Policy # _____ Group # _____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Patient Signature _____ Date: _____

INTEGRATED GENETICS INTERNAL USE ONLY

By signing this form, I hereby authorize Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to LCAH.

I understand that I am responsible for any amounts not paid by insurance for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.

Bill Codes:	Chromosome Analysis	Abbreviated Chromosome Analysis	Reveal® SNP Microarray
	100 Amniotic Fluid	101 Amniotic Fluid	477 Prenatal
	110 CVS	111 CVS	478 POC
	123 PUBS	124 PUBS	
	180 POC/Fetal Tissue	181 POC/Fetal Tissue	

*REFLEX POLICY: The following will be performed by reflex at an additional charge. **AChE** when AF-AFP is elevated &/or gestational age is out of range of normative values. **Fetal Hemoglobin** when AF-AFP is elevated and amniotic fluid is bloody.