LCA Use Only.
Please place accessioning sticker here.

Clinical Questionnaire for **Reveal® SNP Microarray - Pediatric**

This form should be completed when Reveal® SNP Microarray - Pediatric testing is ordered. The form should be completed by the ordering physician's office and should accompany the sample. Please call 800-345-GENE (4363) and ask to speak to a cytogenetics genetic counselor with any questions.

Patients name: _____ Date of birth: _____

Gender: ❍ Male ❍ Female Name of person completing form: _____

Primary Diagnosis

Development (any delays): _____

Cognitive: _____ ❍ Suspect autism spectrum disorder

Motor (gross): _____ (fine motor): _____

Growth (delays/overgrowth, etc): _____

Other: _____

Any dysmorphic features (unusual facial characteristics): _____

Review of Systems (please comment on any issues/problems/abnormal studies associated with each system)

Neurological/Mental: _____

Chest/Lungs: _____

Heart: _____

Genital/Urinary: _____

Skeletal/Liimbs: _____

Eyes/Skin: _____

Other: _____

Prenatal History

Any signficant prenatal history: _____

Abnormal labs: _____

Chromosome analysis results: _____ Year performed?" _____

Significant Family History

❍ Unknown or limited family history? Please explain (eg, adopted) _____

Relative*	Maternal / Paternal	Condition/Clinical Diagnosis/Previous Genetic Test Results	Has genetic testing been performed? If yes, attach lab report.
	❑ / ❑		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No
	❑ / ❑		❑ Yes ❑ No

Are the parents related (other than by marriage, for example first or second cousins)? If so, how?: _____

Ordering provider understands by signing below:
Pretest counseling, which includes an interpretation of family and medical histories; education about inheritance, genetic testing, disease management, prevention, and resources; counseling to promote informed choices and adaptation to the risk or presence of a genetic condition; and counseling for the psychological aspects of genetic testing, has been completed where required by health plan. Post-test counseling will be available.

Account No.: _____

Provider Name (print): _____ NPI: _____

Provider Phone No.: _____ Fax No.: _____

_____ / _____

Ordering Provider Signature **Date**

Patient understands by signing below:
LabCorp may use information obtained on this form and other information provided by me and/or my ordering provider or his/her designee to initiate prior authorization with my health plan as required. I understand a prior authorization approval from my health plan does not guarantee full payment. It is my responsibility to contact my health plan regarding concerns over my coverage and benefits.

_____

Patient Signature

_____

Date

LabCorp
www.LabCorp.com

Additional copies of this form can be printed from our website: www.integratedgenetics.com.

Integrated GENETICS
LabCorp Specialty Testing Group