Integrated GENETICS
LabCorp Specialty Testing Group

POSTNATAL 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:

NPI#: Taxonomy#:

Referring Physician (print):

Genetic Counselor (print):

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

Collection date: / / Date sent: / / Collected by:

Specimen Type (Check one specimen type.) ☐ Peripheral Blood

☐ POC/Fetal Tissue (GA wks _____ tissue origin _____ fetal sex if known _____)

☐ Skin Biopsy ☐ Cord Blood ☐ Blood Spot Card ☐ Mouthwash ☐ Buccal swab

Laboratory Test(s) Ordered

See back ☐ Chromosome Analysis

See back ☐ If chromosomes are normal, reflex to Reveal® SNP Microarray

478 ☐ If POC/tissue fails to grow, reflex to Reveal® SNP Microarray – POC*

476 ☐ Reveal® SNP Microarray – Pediatric*

478 ☐ Reveal® SNP Microarray – POC*

See back ☐ Reveal® SNP Microarray & Abbreviated Chromosome Analysis‡

☐ Parental follow up to abnormal microarray (additional charges may apply)

Test code on original report: _____

(Attach copy of original report or name of patient previously tested)

162 ☐ Mosaicism

140 ☐ DEB Breakage Study (routine chromosome analysis included)

FISH

105 ☐ InSight® (FISH for 13, 18, 21, X and Y)

286 ☐ Angelman

287 ☐ Cri-Du-Chat

287 ☐ DiGeorge/VCF

287 ☐ Kallmann

287 ☐ Miller-Dieker

286 ☐ Prader-Willi

287 ☐ Smith-Magenis

287 ☐ Steroid Sulfatase Deficiency

287 ☐ Williams

287 ☐ Wolf-Hirschhorn

☐ Other FISH – specify _____

Single Gene Disorders

521 ☐ Fragile X, PCR & Southern **#

530 ☐ CF*plus*® (97 mutation test)

582 ☐ If CF*plus*® is not positive for 2 mutations, reflex to full sequencing

538 ☐ Poly(T) Testing for CFTR Intron 8

Cystic Fibrosis (CFTR): 451910 ☐ Gene-specific Sequencing ☐ 451382 Mutation-specific Sequencing

Mutation(s) _____

565 ☐ Angelman Syndrome Methylation Analysis

565 ☐ Prader-Willi Methylation Analysis

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

*To provide testing on patients from New York state, routine cytogenetics must also be performed.
☐ NY clients check here to indicate this has been done.
Not currently NY state approved.
** Maternal cell contamination analysis required for all prenatal dx (send a maternal sample).
# Dx test for prenatal samples/symptomatic/family history

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

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	

If ordering Reveal® SNP Microarray please submit Clinical Questionnaire

☐ Family history of:
- ☐ Chromosome abnormality – specify _____
- Specify relationship of affected individual _____
- ☐ ID/DD
- ☐ Autism/Autism spectrum disorders
- ☐ Birth defects (specify) _____
- ☐ Other (specify) _____

☐ Parent has chromosome rearrangement/mosaicism–specify _____

☐ Multiple congenital anomalies
- ☐ CNS _____
- ☐ Facial dysmorphism _____
- ☐ Heart _____
- ☐ Genitourinary _____
- ☐ Growth/skeletal _____
- ☐ Eye/skin _____
- ☐ Other _____

☐ Clinical features of chromosome abnormality – specify _____

☐ Failure to thrive ☐ Child ☐ Newborn

☐ Developmental delay
- ☐ Cognitive ☐ Gross motor ☐ Fine motor ☐ Growth

☐ Intellectual disability (ID)
- ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

☐ Autism/Autism spectrum disorders

☐ Parental chromosome analysis following abnormal postnatal results

Specify _____

☐ Clarify abnormal chromosomes – provide results and a copy of the karyotype

_____

☐ Fetal loss/Stillbirth (POC) ☐ <20 wks ☐ >20 wks

☐ Multiple SABs (spontaneous abortion)

☐ Identification of complete or partial mole (POC)

☐ Other infertility _____

☐ 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 _____

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
	120 Peripheral Blood	124 Peripheral blood	476 Pediatric
	180 POC/Fetal Tissue	181 POC	478 POC
	183 Skin Biopsy		

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