Washington University Physicians®

Clinical Genomics Laboratory - Cytogenetics: Constitutional

Shipping Address

Washington University Pathology Services
Clinical Support Office
425 S. Euclid Ave., Room 4701
MSC 8024-14-4711
St. Louis, MO 63110

Sample drop-off locations:

Clinical Support Office
509 S. Euclid Ave.
4th Floor West Bldg, Room 4711
St. Louis, MO 63110
Tel: (314) 454-8101
(8:00am - 5:00pm)

Institute of Health (IOH) Core Lab
425 S. Euclid Ave., Room 4701
St. Louis, MO 63110
Tel: (314) 362-1470
AFTER HOURS

Office use only
Date/Time Received:
Accession Number:
Technician Initial:

This requisition has two pages, please complete it completely and accurately.

PATIENT IDENTIFICATION					PHYSICIAN ORDER TEST (NPI required)		
Name Last:	First:		MI:		Name Last:	First:	MI:
DOB (mm/dd/yyyy):	Sex:	Male:	Female:	Ambiguous:	NPI:	Email:	
Address:					Phone:	Fax:	
City:	State:	Zip:			Address:		
					City:	State:	Zip:

SPECIMEN (check one)

Date Specimen Collected:

Peripheral Blood	Skin Biopsy	Chorionic Villi	Amniotic Fluid	Products of Conception	Cord Blood

Tissue Biopsy, specify:

CLINICAL INFORMATION

Clinical Diagnosis/Physical Findings:						ICD10 Code:	
						FOR PRENATAL STUDIES	
						Gestational age:	
						Sex by ultrasound	
Is the subject pregnant?	Yes	No				Gravida:	Para:
Developmental Delay?	Yes	No	Intellectual Disability?	Yes	No	SAB:	TAB:

TESTING REQUESTED (check all that apply)

CHROMOSOME ANALYSIS

- ☐ Karyotype/chromosome analysis
- ☐ Sex chromosome study/Mosaicism Analysis (use for marker chromosomes*)

FLUORESCENCE IN-SITU HYBRIDIZATION

- ☐ DiGeorge/VCF, *TUPLE1* (22q11.2)
- ☐ Wolf Hirshhorm, *WHS* (4p16)
- ☐ Prader-Willi, *SNRPN* (15q11q13)
- ☐ Angelman, D15S10 (15q11q13)
- ☐ William syndrome, *ELN* (7q11.23)
- ☐ Smith Magenis, *SMS* (17p11.2)
- ☐ Other FISH tests, specify:
- ☐ Aneuscreen (13/21, 18/X/Y)
- ☐ Cri du Chat, *CDCR* (5p15)
- ☐ 1p36 deletion, p58
- ☐ Kallman, *KAL* (Xp22.3)
- ☐ Steroid sulfatase def, *STS* (Xp22.3)
- ☐ SRY gene, *SRY* (Yp11.3)

CHROMOSOMAL MICROARRAY (CMA)

- ☐ Genomic copy number assay microarray, (requires Sodium Heparin AND EDTA tubes)
- ☐ CMA only
- ☐ CMA with reflex karyotype (where medically indicated)**
- ☐ CMA with concurrent karyotype
- ☐ CMA with abbreviated karyotype
- ☐ CMA familial FISH

FIBROBLAST CULTURE (PLEASE CALL LAB)

- ☐ Grow/Freeze
- ☐ Grow/Send out***:
- ☐ Test:
- ☐ Referral Lab:

*Please enclose a copy of previous pertinent genetic testing
**Karyotype performed for normal result or to further define a cytogenetically visible structural or numerical abnormality
***Clinical history, letter of financial responsibility, FedEx account number and any related requisitions are required for all sendouts

REFERRING PHYSICIANS (Name, address, and contact information of ordering physician is required. Residents must include attending physician contact information)

Doctor:

Address:

Tel:	Fax:	Pager:

PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):

INSURANCE AND PRECERTIFICATION

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered charges for genetic testing. Other out-of-state welfare programs cannot be billed. Please contact our Patient Accounts Manager office at 314-362-5641 or via e-mail at path-billing@email.wustl.edu for complete insurance filing information and the managed care contract list.

Prior Authorization Number:	ICD10 Code(s):
CPT Codes and Units Authorized:	

ATTACH COPY OF INSURANCE CARD (if not available, complete the following)

Policy Holder's Name: Last First MI	Insurance Co. Name:	
	Insurance Co. Phone:	
Policy Holder's Date of Birth (mm/dd/yyyy):	Plan Name:	
Relationship to patient:	ID#:	Group#:

SELF-PAY / PATIENT FINANCIAL ASSISTANCE

Patients who are self-pay should contact our office to arrange for payment. Financial assistance may be available. For more information, contact our Patient Accounts Manager office at 314-362-5641 or via e-mail at path-billing@email.wustl.edu.

Reference Laboratories: complete section below

INSTITUTIONAL BILLING

Institution Name:		
Contact Name:		
Email:		
Billing Address:		
City:	State:	Zip:
Phone:	Fax:	