WashU Medicine

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 both pages to ensure testing.

PATIENT IDENTIFICATION

Patient Status: ☐ Inpatient ☐ Outpatient ☐ Office Visit

Name Last: | First: | MI:

DOB (mm/dd/yyyy): | Sex: ☐ Male ☐ Female

Medical Record # (if applicable):

Address:

City: | State: | Zip:

Ethnicity (select all that apply)

☐ African American ☐ Asian ☐ Caucasian/NW European
☐ E Indian ☐ Hispanic ☐ Jewish-Ashkenazi ☐ Jewish-Sephardic
☐ Mediterranean ☐ Native Hawaiian/Pacific Islander ☐ Other

PHYSICIAN Ordering TEST *(NPI required)*

Name:

Institution:

NPI: | Email:

Address:

City: | State: | Zip:

Phone: | Fax:

Alternative Contact Information:

Phone: | Email:

Notes:

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)
- ☐ Prader-Willi, SNRPN (15q11q13)
- ☐ Other FISH tests, specify:
- ☐ Aneuscreen (13/21, 18/X/Y)
- ☐ 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 ☐ Test:
- ☐ Grow/Send out***: ☐ 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:

WashU Medicine

PATIENT INFORMATION

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

BILLING INFORMATION
(CHECK ONE)

☐ **Bill Patient/Insurance-Complete Section A** ☐ **Bill Submitting Institution-Complete Section B**

SECTION A-PATIENT/INSURANCE BILLING INFORMATION

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. For MEDICAID patients, Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered services. Other out-of-state welfare programs cannot be billed. Please contact our Patient Accounts Manager office at (314) 362-5641 or via email 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 Unit Authorized:	

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

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

SECTION B-INSTITUTIONAL BILLING

Institution Name:		
Contact Name:	PO Number (if applicable):	
Email:		
Accounts Payable Billing Address:		
City:	State:	ZIP:
Phone:	Fax:	