

Shipping Address

Washington University Pathology Services
 Cytogenetics and Molecular Pathology Laboratory
 660 S. Euclid Ave. | MSC 8118-99-02 | St. Louis MO 63110
 Tel: (314) 454-8101 | Fax: (314) 362-8296
 On-Call Pager: (314) 407-0269

Sample drop-off locations:

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

Children's Hospital
 One Children's Place
 Central Receiving 2N-25
 St. Louis, MO 63110
 Tel: (314) 454-4161

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
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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 <input type="checkbox"/> Karyotype/chromosome analysis <input type="checkbox"/> Sex chromosome study/Mosaicism Analysis (use for marker chromosomes*)	CHROMOSOMAL MICROARRAY (CMA) <input type="checkbox"/> Genomic copy number assay microarray, (requires Sodium Heparin AND EDTA tubes) <input type="checkbox"/> CMA only <input type="checkbox"/> CMA with reflex karyotype (where medically indicated)** <input type="checkbox"/> CMA with concurrent karyotype <input type="checkbox"/> CMA with abbreviated karyotype <input type="checkbox"/> CMA familial FISH
FLUORESCENCE IN-SITU HYBRIDIZATION <input type="checkbox"/> DiGeorge/VCF, <i>TUPLE1</i> (22q11.2) <input type="checkbox"/> Wolf Hirshhorn, <i>WHS</i> (4p16) <input type="checkbox"/> Prader-Willi, <i>SNRPN</i> (15q11q13) <input type="checkbox"/> Angelman, <i>D15S10</i> (15q11q13) <input type="checkbox"/> William syndrome, <i>ELN</i> (7q11.23) <input type="checkbox"/> Smith Magenis, <i>SMS</i> (17p11.2) <input type="checkbox"/> Other FISH tests, specify:	<input type="checkbox"/> Aneuscreen (13/21, 18/X/Y) <input type="checkbox"/> Cri du Chat, <i>CDCR</i> (5p15) <input type="checkbox"/> 1p36 deletion, p58 <input type="checkbox"/> Kallman, <i>KAL</i> (Xp22.3) <input type="checkbox"/> Steroid sulfatase def, <i>STS</i> (Xp22.3) <input type="checkbox"/> SRY gene, <i>SRY</i> (Yp11.3)
FIBROBLAST CULTURE (PLEASE CALL LAB) <input type="checkbox"/> Grow/Freeze <input type="checkbox"/> Grow/Send out***: <input type="checkbox"/> Test: <input type="checkbox"/> 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):
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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:	