Washington University Physicians
Washington University School of Medicine in St. Louis

CYTOGENETICS: Constitutional

Cytogenetics and Molecular Pathology Laboratory

Division of Laboratory and Genomic Medicine
Department of Pathology & Immunology
660 S. Euclid Ave., Campus Box 8118, St. Louis MO 63110
Tel: (314) 454-8101 | Fax: (314) 362-4080
On-Call Pager: (314) 407-0269

Sample drop-off locations:

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

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

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

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

HOSPITAL STAMP

Date Specimen Collected:

Hospital Unit#:

IMPORTANT: Studies cannot be completed without adequate patient identification and clinical information

PATIENT IDENTIFICATION

Name Last:	First:	MI:
DOB (mm/dd/yyyy):	Sex: ◯ Male ◯ Female ◯ Ambiguous	
Address:		
City:	State:	Zip:

SPECIMEN (check one)

◯ 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:			Doctor:		
Address:			Address:		
Tel:	Fax:	Pager:	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:	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#:

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.

AUTHORIZATION TO ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY FOR ACCOUNT

I authorize the disclosure of insurance benefit coverage and payment information to Washington University School of Medicine. I authorize Washington University School of Medicine to furnish any medical information requested on myself, or my covered dependents. I assign and authorize insurance payments to Washington University School of Medicine. I understand I am responsible for any co-pay, deductibles, or non-authorized services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if Washington University School of Medicine is not a participant with my health plan, and/or my health plan does not fully reimburse medical services due to lack of authorization or medical necessity.

Signature of Patient or Guardian	Printed Name of Patient or Guardian	Date

Reference Laboratories: complete section below

INSTITUTIONAL BILLING

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