CytoGenX
Medical Genetic Laboratories

www.CytoGenX.com

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Stony Brook, NY 11790
1-888-GENE-MED

GENETIC TEST REQUISITION

Today's Date: / /

Name *(Last, First, M.I.):*	Biological Sex ☐ M ☐ F	**DOB:**	**OB:**
Street Address:	**City:**	**State:**	**ZIP:**
Social Security #:	**Cell Phone: ( ) -**	**E-mail address:**	

INSURANCE INFORMATION

Primary insurance: **(attach copy of card)**	Policy holder's name:	DOB:
Policy ID#:	Group #:	Relation to policy holder: ☐ self ☐ spouse ☐ child ☐ other
Policy holder's SS#:	Employer:	Address:
Secondary Insurance **(attach copy of card)** :		

REFERRING PHYSICIAN/FACILITY

Facility Name:	Referring Physician:	
Reporting Address:	Genetic Counselor/Contact:	
Reporting Phone: ( )	Reporting Fax: ( )	NPI #:

CLINICAL INFORMATION

Sample Type: ☐ Amniotic fluid ☐ CVS ☐ Blood ☐ POC ☐ Other _____			Pregnancy: ☐ YES ☐ NO	IVF pregnancy: ☐ Yes ☐ No
Date drawn: / /	G: _____ P: _____	EDD: / / LMP: / /	Multiple pregnancy: ☐ No ☐ Yes # of fetuses ___	☐ Donor Egg? ☐ Donor Sperm?
Gestation on date drawn: _____wks _____days		Ethnicity: ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ AJ ☐ other _____		

INDICATION FOR PROCEDURE

- Include any available records for testing and billing purposes -

ICD 10 Dx code(s): _____ (required)

☐ AMA ☐ SAB ☐ U/S abnormality ☐ NT=_____mm ☐ Cystic Hygroma ☐ Heart defect ☐ Other:_____	☐ Positive serum screen: _____ ☐ Positive MSAFP: _____ ☐ Positive NIPT ☐ Trisomy 21 ☐ Trisomy 18 ☐ Trisomy 13 ☐ Sex Chrm Abn: _____ ☐ No-call (low ff) ☐ Atypical findings:_____	☐ Family history of genetic cond. Specify: _____ ☐ Previous child with: ☐ Genetic condition: _____ ☐ Congenital defect: _____ ☐ ID/DD ☐ Other, Specify: _____	☐ Known carrier or carrier couple of AR/XLR disease specify: _____ Father of pregnancy ☐ carrier ☐ not tested	☐ Amniocentesis follow-up for abnormal CVS ☐ ID/Developmental delay ☐ Multiple miscarriages ☐ Other: _____	☐ Infertility ☐ Female factor ☐ Male factor ☐ Oligospermic ☐ CBAVD

LABORATORY TESTS ORDERED

- In case of sample limitations, decisions regarding testing prioritization will be made. Please indicate highest priority testing -

☐ 24-hr STAT FISH ☐ 13,18,21,X,Y ☐ 22q/DiGeorge ☐ Prader Willi ☐ Other: _____	☐ Fetal Chromosome analysis ☐ Blood Chromosome analysis *5mL sodium heparin (green-top) req.*	☐ MCC *(5mL maternal EDTA lav req.)* ☐ AF-AFP	☐ SNP microarray ☐ Direct ☐ Reflex if normal chroms	☐ autosomal recessive disease. Gene: _____ *Call ahead to coordinate Records and parental blood samples req. – 5mL EDTA lav*	☐ X-linked recessive disease. Gene: _____ *Call ahead to coordinate Records and maternal blood sample req. – 5mL EDTA lav*

☐ WES ☐ Direct ☐ Reflex ☐ Y-Chrom microdel	☐ Noonan syndrome panel ☐ Direct ☐ Reflex if normal chroms ☐ Reflex if normal array	☐ Parental follow-up for: _____	☐ Hold cells pending: ☐ Carrier screening ☐ Ultrasound, date: _____ ☐ Other, date: _____	☐ Additional testing for: _____ ☐ Viral Studies, specify: _____

For Regulatory Compliance The Following Consent Must Be Completed and Signed by the Physician and the PATIENT:

This patient received appropriate information about the nature of the testing process and gives informed consent to be tested. If prenatal testing is performed, the patient also consents to release relevant information on the outcome of her pregnancy to this laboratory.

** Physician's Signature: _____ Date: / /

I hereby acknowledge that I have received information regarding the nature of the testing process and give my consent to be tested. I understand that my sample is not being banked. Once my test is completed, my DNA may be used anonymously (stripped of identifiers) for research or control purposes. I hereby authorize my insurance benefits to be paid directly to CYTOGENX, and authorize the release of any medical information concerning my testing requested by my insurer. I authorize CYTOGENX to initiate any complaints to the insurance commissioner on my behalf. I hereby acknowledge that I am financially responsible for any amounts not paid by my insurer, including related collection costs, all reasonable attorney fees and late interest penalties assessed on delinquent accounts. I hereby authorize CYTOGENX to charge my credit card for any patient responsibilities not covered by my insurance plan.

** Patient (or Guardian) Signature: _____ Date: / /

Credit card Number: _____ Expiration Date: / /