

PLEASE SUBMIT A SEPARATE REQUISITION FOR EACH PATIENT, INCLUDING TWINS

Highlighted fields are required.

Name _____
Last First MI

Address _____

City _____ State _____ Zip _____

Male Female Date of Birth _____ / _____ / _____

Home Phone _____ Work Phone _____

Social Security Number _____

Lab # _____ Hospital # _____

I attest that this patient has been informed about and has given consent for the test(s) I have ordered below.

Referring Physician/Designee (print): _____

Physician/Designee (signature): _____

Genetic Counselor (print): _____

Laboratory Tests Ordered and Clinical Information/Test Indications (Check all that apply)

Date drawn: _____ / _____ / _____ Drawn by: _____

Specimen Type (Check one):

Parental Peripheral Blood Mouthwash (Please call) Guthrie Card

Fetal Fetal Blood Amniotic Fluid Chorionic Villi POC

Back-up culture by: Genzyme Other _____ Hold for: _____

Ethnicities (Check all that apply):

Caucasian Ashkenazi Jewish Sephardic Jewish Asian African American

Native American Hispanic Other: _____

Single Gene Disorders/Diseases

Ashkenazi Jewish Testing
(may be appropriate for other ethnicities)

Check here for all Ashkenazi Jewish Carrier Tests or check separately

562 Bloom syndrome*

554 Canavan disease*

530 CFplus® (97 mutation test)†*

519 Dihydropyrimidine dehydrogenase deficiency*

207 Familial dysautonomia*

585 Familial hyperinsulinism*

534 Fanconi anemia (Group C)*

595 Gaucher disease*

522 Glycogen storage disease type 1a*

518 Maple syrup urine disease*

573 Mucopolidiosis type IV*

587 Nemaline myopathy*

557 Niemann-Pick type A*

593 Tay-Sachs enzymes and DNA*

350 Tay-Sachs enzymes only

589 Usher syndrome type IF*

599 Usher syndrome type III*

If pregnant: GA _____ weeks
 *Call before sending if for Fetal DNA. Maternal cell contamination analysis required for all prenatal dx (send a maternal sample).

Pan Ethnic Testing

Check here for all Pan Ethnic Carrier Tests or check separately

530 CFplus® (97 mutation test)†*

520 Fragile X syndrome*

516 Spinal muscular atrophy (SMA)*
 Both parents bloods required for prenatal dx

Other Tests

538 Poly (T) Testing for CFTR Intron 8

528 Maternal cell contamination*

591 Y chromosome microdeletions

535 Sickle cell anemia* (prenatal dx only)

574 Rhc/E (also send parental bloods)*

575 RhD (also send parental bloods)*

593 Tay-Sachs DNA (prenatal dx only)*

Other test: _____

Thrombophilia

549 Factor II (prothrombin G20210A)

548 Factor V (Leiden)

526 MTHFR (C677T)

Clinical Information/Single Gene Testing (If not checked, screening will be assumed)

Parental: No family history (screening) Abnormal fetal U/S* Family hx: relative*
 Known carrier* Congenital absence of vas deferens Infertility
 Gamete donor Thrombophilia*

Fetal: Abnormal fetal U/S* Family hx: relative* Parent(s) known carrier(s)*

*Provide additional information: _____

Maternal Serum Screening

315 FirstScreen®* (10w 3d – 13w 6d)

335 SequentialScreenSM*

302 IntegratedScreenSM*

302 Serum IntegratedScreenSM* (without NT measurement)

325 AFP4® (15w 0d – 21w 6d)

310 MSAFP (ONTD only; 15w 0d – 23w 6d)

*Dried blood spot samples acceptable for first trimester only.

Clinical Information for Maternal Serum Screening

Gravida: _____ Para: _____ SAB: _____ TAB: _____

U/S date: _____ / _____ / _____ GA on U/S date: _____ wks _____ days

Sonographer Name: _____ NTQR ID# _____

Reading MD NTQR ID#: _____ Practice Location ID#: _____

NT: _____ mm CRL: _____ mm

(Twin, if applicable) NT: _____ mm CRL: _____ mm

LMP date: _____ / _____ / _____ EDC date: _____ / _____ / _____ by U/S LMP PE IVF

IVF fertilization date: _____ / _____ / _____ IVF egg donor age (if applicable): _____

Maternal Weight _____ lbs. # Fetuses: 1 2 >2 Repeat Screen

Y N Patient is Rx-dependent diabetic prior to pregnancy (insulin or oral hypoglycemics)

Y N Previous Down syndrome pregnancy/child

Y N Family hx of NTD, specify: _____ Relative: _____

Cytogenetics/FISH/Biochem

100 Amniotic fluid chromosomes

300 AF-AFP†

330 Acetylcholinesterase (AChE)

110 CVS chromosomes

105 InSight® (FISH for 13, 18, 21, X, Y)

287 DiGeorge/VCF (22q11.2 deletion)

Other FISH: _____

123 Fetal blood (PUBS) chromosomes

180 POC chromosomes: GA week: _____

POC tissue type: _____

120 Blood Chromosomes (parental)

Other _____

Clinical Information/Test Indications for Cytogenetics/FISH

Gravida: _____ Para: _____ SAB: _____ TAB: _____ # Fetuses: 1 2 >2

U/S date: _____ / _____ / _____ LMP date: _____ / _____ / _____ GA: _____ wks _____ days by U/S LMP

AMA

Positive serum screen: NTD Down syndrome Trisomy 18

Abnormal fetal U/S: CNS* Other*

Family history of: NTD Chromosome abnormality* MR* Other*

Parental cytogenetics following abnormal prenatal results*

Multiple spontaneous abortions (SAB)

*Provide additional information: _____

†Reflex policy: The following will be performed by reflex at additional charge: AChE when AF-AFP is elevated; Fetal HGB when AF-AFP is elevated and amniotic fluid is bloody; CFTR Intron 8 poly(T) when R117H CF mutation is present.

BILLING INFORMATION

BC/BS HMO PPO Indemnity Network Medicaid

Medicare Medical Group/IPA Client Bill CA XAFP Self-Pay

Billing Information Attached (Please include a copy of insurance card or face sheet.)*

*Do not attach credit card information to this form for security purposes.

Insurance Company Name _____

Policy # _____ Group # _____

Relation to Insured: Self Spouse Child Other _____

Patient Signature _____

GENZYME GENETICS INTERNAL USE ONLY

Non-Medicare Patients: I hereby authorize Genzyme Genetics to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to Genzyme Genetics. I understand that I am responsible for any amounts not paid by insurance for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.

