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.):*	☐ M ☐ F	**DOB:**	**OB:**
Street Address:	**City:**	**State:**	**ZIP:**
Social Security #:	**Home Phone: ( ) -**	**Work Phone: ( ) -**	

INSURANCE INFORMATION

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

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 ☐ Tissue ☐ Urine ☐ Blood spot card ☐ Buccal Swab ☐ Other _____

Date drawn: / /	Gravida: _____ Para: _____	Multiple pregnancy ☐ Yes ☐ No # of fetuses __	IVF pregnancy ☐ Yes ☐ No
Pregnancy: ☐ YES ☐ NO	Gestation on ultrasound date: _____wks _____days	U/S date: / /	LMP: / /

Ethnicity: ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Ashkenazi Jewish ☐ Sephardic Jewish ☐ Native American ☐ other _____

INDICATIONS

ICD 9 Dx code(s): _____ (required)

☐ Positive serum screen: ☐ Positive NIPT ☐ NTD ☐ Down syndrome ☐ Trisomy 18 ☐ Trisomy 13 ☐ Sex Chrm Abn: _____	☐ U/S abnormality ☐ NT=_____mm ☐ Cystic Hygroma ☐ Echogenic bowel ☐ Heart defect ☐ other:_____ _____	☐ Family history of: ☐ Previous child with: ☐ NTD ☐ Chromosome abnormality ☐ Mental Retardation ☐ Other: _____ _____	☐ Infertility ☐ Female ☐ Male factor ☐ Oligospermic ☐ Azoospermic ☐ CBAVD	☐ Multiple miscarriage ☐ SAB ☐DIU	☐ AMA ☐ MR/Developmental delay ☐Bladder Cancer
☐ Parental chromosome studies	☐ Known Carrier of: _____	☐ Confirmatory studies (Enclose copy of previous results)	☐ Carrier screening	☐ Other: _____ _____	

LABORATORY TESTS ORDERED

☐ Chromosome analysis	☐ 24-hr STAT FISH (13,18,21,X,Y)	☐ AF-AFP	☐ SNP microarray	☐ DiGeorge/VCFS	☐ Other FISH specify: _____	☐ UroVysion

☐ Y Chromosome microdeletion	☐ Cystic Fibrosis	☐ MCC	☐ Additional testing for: _____ _____	☐ Hold cells pending results of: _____ _____	☐ If chromosomes are normal reflex testing for: ☐ Noonan ☐ SNP Microarray ☐ Other: _____

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: / /