CONSTITUTIONAL CYTOGENETICS REQUISITION

MLabs
Expertise Delivered Personally

MLabs N-LNC Specimen Processing
Department of Pathology & Clinical Laboratories
2800 Plymouth Rd, Bldg 35
Ann Arbor, MI 48109-2800
734-936-2598 • 800-862-7284
www.mlabs.umich.edu

Client
REFR

Ward
REFR

Patient Reg or MRN:

Patient Name: Last First MI

Birthdate: Gender: ○M ○F

Ordering Doctor: Last First NPI#

Patient Address City State ZIP Home Phone #

Policy Holders Name | Primary Insurance (Card Name) | Primary Policy/Contract # | Primary Group # | Policy Holders DOB

Policy Holders Name | Secondary Insurance (Card Name) | Secondary Policy/Contract # | Secondary Group # | Policy Holders DOB

Bill To: ☐ Client/Referring Institution ☐ Patient/Insurance

☐ Medicare = ☐ In Patient on DOS ☐ Out Patient on DOS ☐ Non Patient on DOS

If patient or insurance information is not included or attached to this form, your facility will be billed. For Medicare patients classified as a hospital inpatient or outpatient on the date of service, charges must be billed to the referring client.

ICD-10 CODES

ICD-10 Codes are required for billing. When ordering tests for which reimbursement will be sought, order only tests that are medically necessary for the diagnosis and treatment of the patient.

REFERRING PHYSICIAN TO BE CONTACTED WITH RESULTS AND/OR QUESTIONS

Referring Physician | Referring Institution | Phone | Fax

Address | City | State | ZIP | Country

This request to order tests from MLabs certifies to MLabs that (1) the ordering physician has obtained written informed consent from the patient as required by applicable state or federal laws for each test ordered and (2) the ordering physician has authorization from the patient permitting MLabs to report results for each test ordered to the ordering physician.

PROCESSING

Collection Date: _____ Time: _____ (○am ○pm) Footnote: Case/Accn # _____

MATERIALS SENT

☐ Peripheral Blood

☐ Products of Conception (POC) LMP: _____ Gestational Age: _____ based on ☐ LMP or ☐ Ultrasound

PATIENT HISTORY/DIAGNOSIS (REQUIRED)

Please indicate suspected diagnosis or indication for Cytogenetic testing:

The tests below may include reflex testing and/or pathologist interpretation at an additional charge. See MLabs Test Catalog at www.mlabs.umich.edu for specimen collection and handling requirements.

CONSTITUTIONAL / GENETICS

☐ Chromosome Analysis (Culture and Karyotype)

FISH FOR GENETIC DISORDERS

☐ DiGeorge/VCF Syndrome (22q11.2)

☐ Williams Syndrome (7q11.23)

☐ Other:_____