



CONSTITUTIONAL CYTOGENETICS REQUISITION

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	Patient Reg or MRN:		
	Patient Name: Last	First	MI
Ward	Birthdate:		Gender: OM OF
	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:	<input type="checkbox"/> Client/Referring Institution	<input type="checkbox"/> Patient/Insurance	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.
	<input type="checkbox"/> Medicare = <input type="checkbox"/> In Patient on DOS <input type="checkbox"/> Out Patient on DOS <input type="checkbox"/> Non Patient on DOS		

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: _____ (Oam Opm) 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: _____