labcorp

Testing will be performed at a Labcorp laboratory, including formerly branded Integrated Genetics.

For Accessioning
Labcorp PST send to:
2000 Vivigen Way
Santa Fe, NM 87505

# POSTNATAL TEST REQUISITION

Highlighted fields are required.

1A 1B 1C

## Patient Information

Name
Last First MI

☐ Male ☐ Female Date of Birth / /

Address

Home Phone Work Phone

City State Zip

Lab # Hospital #

## Client Information

I have obtained informed consent of the patient (or the patient's authorized representative) for the ordered genetic test(s) in accordance with applicable law.

Physician/Authorized Signature:

NPI#: Taxonomy#:

Referring Physician (print):

Genetic Counselor (print):

Refer to womenshealth.labcorp.com to access informed consent forms for genetic testing.

Collection date: / / Date sent: / / Collected by:

**Specimen Type** (Check one) ☐ Peripheral Blood ☐ Skin Biopsy ☐ Saliva
☐ POC/Fetal Tissue (GA wks _____ tissue origin _____ fetal sex if known _____)
☐ Cord Blood (Prior to/after delivery?) ☐ Buccal swab ☐ Other _____

## Laboratory Test(s) Ordered

See back ☐ Chromosome Analysis
See back ☐ If chromosomes are normal, reflex to Reveal® SNP Microarray
478 ☐ If POC/tissue fails to grow, reflex to Reveal® SNP Microarray – POC*
162 ☐ Chromosome analysis with Mosaicism study
See back ☐ Abbreviated Chromosome Analysis & Reveal® SNP Microarray‡
See back ☐ Reveal® SNP Microarray
☐ Parental follow up to abnormal microarray (additional charges may apply)
Test code on original report: _____
(Attach copy of original report or name and DOB of patient previously tested)
140 ☐ DEB Breakage Study (routine chromosome analysis included)

**FISH**

105 ☐ InSight® (FISH for 13, 18, 21, X and Y)
286 ☐ Angelman
287 ☐ Cri-Du-Chat
287 ☐ DiGeorge/VCF
287 ☐ Kallmann
287 ☐ Miller-Dieker
286 ☐ Prader-Willi
287 ☐ Smith-Magenis
287 ☐ Steroid Sulfatase Deficiency
287 ☐ Williams
287 ☐ Wolf-Hirschhorn
☐ Other FISH – specify _____

**Single Gene Disorders**

481701 ☐ Fragile X Syndrome, Diagnostic
481025 ☐ Cystic Fibrosis (CF), 97 Variants
☐ If CF97 is not positive for 2 variants, reflex to 482449 GeneSeq® PLUS, CFTR
482370 ☐ GeneSeq® PLUS
Gene(s): _____
482449 ☐ GeneSeq® PLUS, CFTR (Cystic fibrosis)
481630 ☐ Spinal Muscular Atrophy (SMA)
482552 ☐ Targeted Variant Analysis
Gene: _____
Variants(s): _____
511210 ☐ Angelman Syndrome Methylation Analysis
511210 ☐ Prader-Willi Methylation Analysis
☐ **Other testing** – specify (call before sending) _____

## Indication(s) for Test (check all that apply)

All diagnoses should be provided by the ordering physician or an authorized designee.
Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required)

| ICD-CM | | ICD-CM | | ICD-CM | |
|---|---|---|---|---|---|

**If ordering Reveal® SNP Microarray please submit Clinical Questionnaire**

☐ Family history of (include report where applicable):
☐ Chromosome abnorm. (specify, incl. relationship) _____
Are parents related? ☐ Yes ☐ No If yes, how are they related? _____
☐ ID/DD
☐ Autism/Autism spectrum disorders
☐ Birth defects (specify) _____
☐ Other (specify) _____
☐ Parent has chromosome rearrangement/mosaicism–specify _____
☐ Multiple congenital anomalies
☐ CNS _____
☐ Facial dysmorphism _____
☐ Heart _____
☐ Genitourinary _____
☐ Growth/skeletal _____
☐ Eye/skin _____
☐ Other _____
☐ Clinical features of chromosome abnormality – specify _____
☐ Failure to thrive ☐ Child ☐ Newborn
☐ Developmental delay
☐ Cognitive ☐ Gross motor ☐ Fine motor ☐ Growth
☐ Intellectual disability (ID)
☐ Mild ☐ Moderate ☐ Severe ☐ Profound
☐ Autism/Autism spectrum disorders
☐ Parental chromosome analysis following abnormal postnatal results
Specify _____
☐ Clarify abnormal chromosomes – provide results and a copy of the karyotype
_____
☐ Fetal loss/Stillbirth (POC) ☐ <20 wks ☐ >20 wks
☐ Multiple SABs (spontaneous abortion)
☐ Identification of complete or partial mole (POC)
☐ Other infertility _____
☐ Other: _____

## BILLING INFORMATION

Patient Hospital Status: ☐ Inpatient ☐ Outpatient ☐ Non-hospital
☐ Medicaid ☐ Medicare ☐ Insurance ☐ 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 _____

**LABCORP INTERNAL USE ONLY**

By signing this form, I hereby authorize Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to LCAH.
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.

| Bill Codes: | Chromosome Analysis | Abbreviated Chromosome Analysis | Reveal® SNP Microarray |
|---|---|---|---|
| | 120 Peripheral Blood | 124 Peripheral blood | 476 Pediatric |
| | 180 POC/Fetal Tissue | 181 POC | 478 POC |
| | 183 Skin Biopsy | | |

B1A


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