Cytogenetics Services Request

Department of Laboratories
4800 Sand Point Way NE FB.2.441
Seattle, WA 98105 (206) 987-2617
http://seattlechildrenslab.testcatalog.org/

Patient's Last Name	First	Middle	Birth date (required)	Sex

Outside Patient Number	Outside Specimen Number	Send Report To
Ordering Provider		Address
Phone Number	Diagnosis/ICD Code	Phone/Fax

*****REQUIRED INFORMATION*****

Healthcare professional to call for information/abnormal results: **NAME** (please print):_____**PHONE#**:_____

REQUIRED SPECIMEN INFORMATION:

DATE COLLECTED: _____/_____/_____ Whole Blood: ☐Na Heparin ☐EDTA

TIME COLLECTED: _____:_____ AM/PM Other: ☐Tissue ☐Fibroblast ☐Other:_____

BLOOD

☐PERIPHERAL ☐CORD

CH-SNP ☐Single Nucleotide Polymorphism (SNP) Array

CH-KARY ☐Peripheral blood karyotype for _____

☐Peripheral blood karyotype + R/O mosaicism for_____

☐Workup for Turner Syndrome

☐Sex determination/ambiguous genitalia (includes 10 metaphase cells by SRY FISH + 20 metaphase cells by G-bands)

CH-FISH ☐Fluorescence *in situ* hybridization (FISH)

☐Velocardiofacial (VCF)/DiGeorge Syndrome 22q11.2 deletion/duplication syndrome

☐Williams Syndrome

☐Other:_____

CH-FAMS ☐Family follow-up study (all information is **required**)

Proband name:_____

Relationship to Proband (please provide pedigree):_____

Test indicated on Proband report: ☐Limited Karyotype

☐FISH ☐SNP Array ☐qPCR

TISSUE

☐TISSUE:_____ ☐PRODUCT OF CONCEPTION

CH-TISSUE ☐Fibroblast Culture ONLY

CH-TISSUE ☐Fibroblast culture + Karyotype

SNP-POC ☐Products of Conception SNP Array

CH-FISH ☐FISH_____ (specify target)

CLINICAL FINDINGS & FAMILY HISTORY

Please include either Diagnosis/ICD Code and/or Clinical Findings for all Cytogenetic testing

_____

_____

_____

_____

(open space for pedigree)

BILLING INFORMATION

PHYSICIAN NOTIFICATION: Only tests that you believe are appropriate for patient care should be ordered. Medicare/Medicaid will pay only for tests that are medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

BILLING NOTIFICATION: All samples will be billed to the referring institution unless complete billing and diagnosis information is provided on this form. Contact Seattle Children's Laboratory Client Services for additional assistance (206) 987-2617.

BILL TO:

☐ **Referring Institution (Preferred)** - Provide billing address or stamp institution's information.
(Institutional billing will be done for all patients with Medicare except for established Seattle Children's patients.)

Billing Address:	Billing Contact Name:
Billing Contact Phone/Fax:	Billing Contact Email:

☐ **Primary Insurance** (Attach copy of card.) ☐ **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		Employer
Primary Care Physician		Phone Number
Insurance Company/Medical Coverage		
Claims Address		Phone Number
Policy Number		Group Number
Subscriber	Sex	Subscriber's DOB

☐ **Secondary Insurance** (Attach copy of card.) ☐ **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Insurance Company/Medical Coverage		
Claims Address		Phone Number
Policy Number		Group Number
Subscriber	Sex	Subscriber's DOB

☐ **Self Pay**- First, call Lab Client Services for pricing. Then, provide credit card information below or enclose a check with the sample.

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		
Name on Credit Card	Payment Amount	CVN
Card Number	Card Type	Expiration

Please visit our test catalog at http://seattlechildrenslab.testcatalog.org for testing information or call:

Lab Client Services (206) 987-2617 Cytogenetics Lab (206) 987-3961

Seattle Children's®
HOSPITAL • RESEARCH • FOUNDATION

Ship to: LABORATORY
4800 Sand Point Way NE, M/S: FB.2.441
SEATTLE, WA 98105