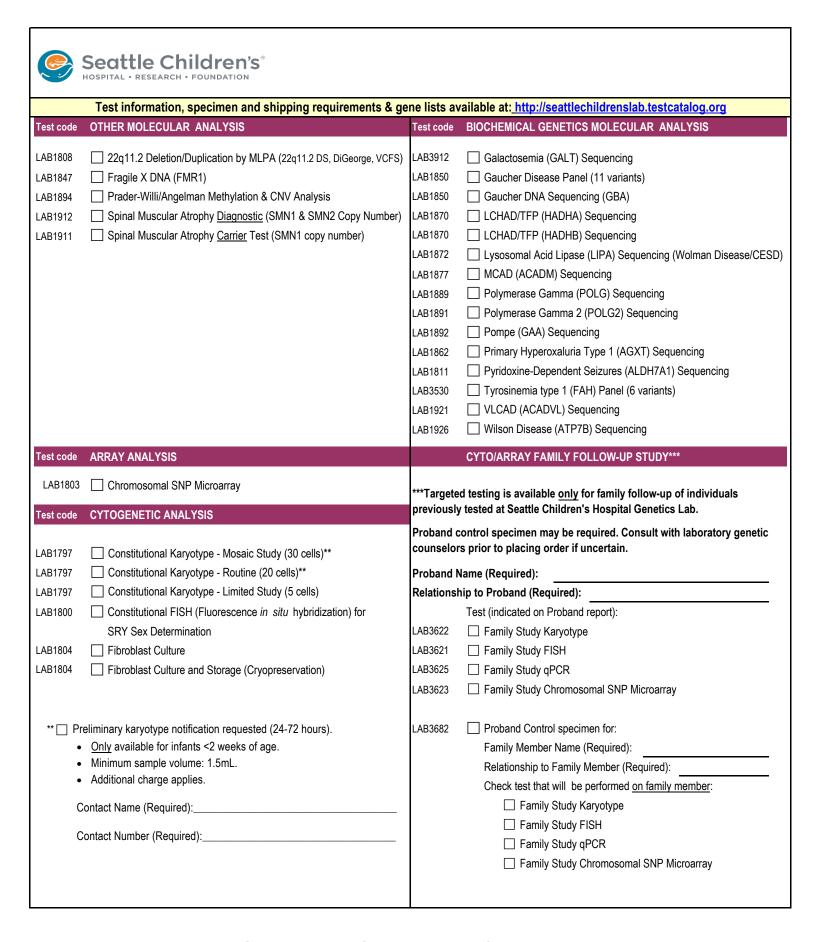


Molecular and Cytogenetics Laboratory

Department of Laboratories 4800 Sand Point Way NE, FB.2.441 Seattle, WA 98105 (206) 987-2617

	FAILURE TO COMPLETE MAY DELAY RESULTS									
Patient's Las	t Name	First			Middle		Birth Date (Required)	Legal Sex		Gender Identity
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	Extracted gDNA from blood									
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FOR S		om Temp	Refrig	☐ Frozen						
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							g delays and impro			
REASON	FOR STUDY: Diagnostic ((affected)	☐ Diagno	estic (not affected)	☐ Carrie	r Testing	(affected family men	nber) 🗀 Carriei	r Testing ((no family history)
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PATIENT PREGNANT? No Yes, estimated due date:										
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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.

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☐ Referring Institution (Preferred) - Provide bil (Institutional billing will be done for all patients with Medical						
Billing Address:		Billing Contact Name:				
				, and the second		
Billing Contact Phone/Fax:				Billing Contact Email:		
☐ Primary Insurance (Attach copy of card.)	☐ Medicaid (On	าly Alas	ska, Idaho,	Montana and Washington Med	licaid are accepted.)	
Patient Address						
Guarantor Name	DC	ОВ		Relationship to Patient		
Guarantor Address (if different from patient's)			1			
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	Se.	ЭX		Subscriber's DOB		
☐ Secondary Insurance (Attach copy of card.)	☐ Medicaid (On	ıly Alas	ska, Idaho,	Montana and Washington Med	licaid are accepted.)	
Insurance Company/Medical Coverage						
Claims Address				Phone Number		
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☐ Self Pay - First, call Lab Client Services for pricing. Th	en, provide credit card info	ormatic	on below or	enclose a check with the samp	ile.	
Patient Address						
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Card Number	Card Type		Expiration			

Please visit our test catalog at http://seattlechildrenslab.testcatalog.org for testing information or call: Lab Genetic Counselors (206) 987-5400 Lab Client Services (206) 987-2617

