CLEAR FORM

Children's Mercy
Dept of Pathology & Laboratory Medicine
2401 Gillham Rd
Kansas City, MO 64108
(816) 234-3835

Postnatal Cytogenetics Requisition

CMH Website Resources

Patient's Name: Last	First	Middle	Birthdate	Gender

Address	City, State, Zip	Phone

Client/Practice Name	Address	City, State, Zip	Phone
Ordering Provider			**Fax**
	Clinician Signature		
ICD 10 (Diagnosis)	MEDICAL NECESSITY REGULATIONS: at the government's request, the Lab would like to remind all physicians that when ordering tests expected to be paid under federal health care programs, such as Medicare and Medicaid, the testing must meet the following conditions: (1) included as covered services, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient and (4) not for screening purposes.		

Billing: ☐Self-pay ☐Insurance - Attach copy of card (both side)	Patient is: ☐Child ☐Self ☐Spouse ☐Other (specify)
Subscriber: Last, First, MI	**Primary: carrier & policy number**
Employer	**Secondary: carrier & policy number**
Insurance Authorization ☐ Not required or Authorization Number:	Valid Date(s):

By submitting this requisition, the ordering physician attests:

1. All requested laboratory tests are medically necessary
2. **Insurance preauthorization has been obtained if required by the payor**

If numeric diagnosis code(s) and an authorization number are not provided as appropriate, the laboratory reserves the right to refuse service.

Specimen Information			STAT
Collection Date:	Time: AM/PM	Collected by:	☐
For best results, send specimen same day as collection. If necessary to hold specimen overnight, keep at room temp – DO NOT FREEZE.			
Diagnosis/Indication			

Results

Physician: _____

Call results to: _____

Fax results to: _____

Tests Requested

☐ Chromosome Analysis, Routine

☐ Chromosome Analysis, High Resolution

☐ Microarray Analysis Copy Number + SNP

☐ Cell Culture & Cryopreservation - Skin / Tissue only

☐ qPCR Parent Confirmation

☐ FISH, specify _____

☐ qPCR Other Family Member

☐ Other test_____

SPECIMEN REQUIREMENTS [blood]

Chromosome Analysis or FISH: 2-3 mL in a Sodium Heparin green top tube; newborn minimum 2 mL

Microarray Analysis / qPCR: 1-2 mL in a EDTA lavender top tube; newborn minimum 1 mL

☐ Peripheral Blood ☐ Cord Blood ☐ Other_____