UW Medicine
PATHOLOGY
CYTOGENETICS & GENOMICS

RESET FORM

1959 NE Pacific St, **Room NW-125**, Seattle, WA 98195
Phone: 206-598-4488 | Fax: 206-598-2610
UWPathology.org/clinical/cytogenetics

CONSTITUTIONAL TEST REQUEST FORM

For UW Pathology use	
MRN:	Accession #

1 Patient Information

First Name		MI	Last Name
Sex	DOB		SSN
Patient Address			
City		State	Zip
Patient Phone #		Outside Facility Patient ID	

2 Requesting Institution

Institution Name			
Institution Address			
City		State	Zip
Person Completing Form			
Phone		Fax	

3 Send Reports to

Requesting Physician (primary):	Phone	Fax	NPI#
Referring Physician/Surgeon:	Phone	Fax	NPI#
Referring Pathologist:	Phone	Fax	NPI#
Additional reports to:	Phone	Fax	NPI#

4 Billing Information

Payment Options: ☐ Patient Insurance* (If outpatient) ☐ Self-Pay (No insurance) ☐ Institution/Client Billing ☐ Split Billing / Medicare* (Pro to Patient, Tech to Client)

**Medicare Billing policy does not permit tech claims on laboratory testing for hospital inpatients/outpatients. These tech charges will be billed to the requesting institution.*

Primary Insurance			Secondary Insurance		
ID/Policy #	Group #		ID/Policy #	Group #	
Insurance Address	Phone		Insurance Address	Phone	
City/State/Zip			City/State/Zip		
Insured's Name	DOB	Relation to Pt:	Insured's Name	DOB	Relation to Pt:

Note: For sample collection requirements see www.pathology.washington.edu/patient-care/cytogenetics-collection

5 Specimen Type

Date obtained:

- ☐ Peripheral Blood
- ☐ Amniotic Fluid (Gestational Age: _____)
- ☐ Chorionic Villi (Gestational Age: _____)
- ☐ Products of Conception (Gestational Age: _____)
- ☐ Fetal Tissue (Site: _____)
- ☐ Umbilical Cord Blood
- ☐ Skin Biopsy (Site: _____)
- ☐ Saliva
- ☐ Paraffin Blocks/Slides (Site: _____)
- ☐ DNA

6 Diagnosis or Indication for Testing

Please attach copy of pedigree if indication is Family History of...

ICD-10 Code: _____

☐ This is a family follow-up study

(Name of proband: _____)

***** SEE PAGE 2 FOR TESTS *****

Ordering Provider Signature Required

Submitting a specimen with this requisition form indicates familiarity and agreement with applicable Reference Laboratory Services policies found at
http://pathology.washington.edu/clinical/servicerequest

Signature	Date

7 Test(s) Requested

☐ **STAT** ☐ ROUTINE

☐ Interphase FISH for common aneuploidies (13, 18, 21, X, Y)

☐ Interphase FISH after pregnancy loss (13, 15, 16, 18, 21, 22, X, Y)

☐ Metaphase FISH for:

- ☐ 1p36.1 deletion
- ☐ 15q11-q13 duplication (autism)
- ☐ 22q11.2 deletion (VCFS/DiGeorge)
- ☐ 22q11.2 duplication
- ☐ Angelman syndrome (15q11.2 deletion)
- ☐ Cri du Chat syndrome (5p deletion)
- ☐ Kallmann syndrome
- ☐ Langer-Giedion (8q24 deletion)
- ☐ Miller-Diecker syndrome (17p13.3 deletion)
- ☐ Pallister-Killian syndrome (iso12p mosaicism)
- ☐ Potocki-Lupski syndrome (17p11.2 duplication)
- ☐ Prader-Willi syndrome (15q11.2 deletion)
- ☐ SHOX-related haploinsufficiency
- ☐ Smith-Magenis syndrome (17p11.2 deletion)
- ☐ Sotos syndrome (5q35 deletion)
- ☐ SRY (46,XX testicular DSD/46,XY DSD/46,XY CGD)
- ☐ Subtelomeres (Specify: _____)
- ☐ Williams syndrome (7q11.23 deletion)
- ☐ Williams-Beuren region duplication (7q11.23 duplication)
- ☐ Wolf-Hirschhorn (4p deletion)
- ☐ X-linked ichthyosis (STS deletion)
- ☐ Other (Specify: _____)

☐ Cytogenomic Microarray Analysis (CMA/CGH/CGAT/SNP Array)

- ☐ Report all findings
- ☐ Do not report variants of uncertain clinical significance

☐ ddPCR (droplet digital PCR) for deletion or duplication (Specify: _____)

☐ Routine G-banded chromosome analysis and karyotyping

☐ Mosaicism study by chromosome analysis and karyotyping

- ☐ Mosaicism for: _____

☐ Limited parental follow-up study by chromosome analysis and karyotyping

☐ Y chromosome deletions by PCR for male infertility

☐ Grow cell cultures for sendout

Sendout instructions:

Reflex Testing

If _____ is ☐ Normal ☐ Abnormal then reflex to _____

If _____ is ☐ Normal ☐ Abnormal then reflex to _____

Patient Insurance Billing Consent

I authorize the Clinical Cytogenomics Laboratory (CCL) to release to my designated insurance carrier, health plan, or third party administrator the information on this form and any other information provided by my health care provider necessary for reimbursement. I assign and authorize insurance payments to CCL. I understand my insurance carrier may not approve and reimburse my medical genetic services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, medical necessity, or otherwise. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles except where my liability is limited by contract or State or Federal law. A duplicate or faxed copy of this authorization is considered the same as the original document.

Patient Signature	**Date**