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 http://www.UWPathology.org/clinical/cytogenetics

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: _____)

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)
- ☐ 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

☐ 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 _____