UW Medicine
LABORATORY MEDICINE & PATHOLOGY

Reset Form

CONSTITUTIONAL TEST REQUEST FORM

1959 NE Pacific St, Room NW-125, Seattle, WA 98195
Phone: 206-598-4488 | Fax: 206-598-2610
https://dlmp.uw.edu/patient-care/cytogenetics
http://uwcpdx.org/clinical-genomics-laboratory/

For UW Pathology use
Accession #

❶ Patient Information

Legal First Name	MI	Legal Last Name
DOB	Patient MRN	
Sex Assigned at Birth	Gender Identity	
Patient Phone #		
Patient Address		
City	State	Zip

❷ Requesting Institution

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

❸ Send Reports to

Ordering Provider	Phone	Fax	NPI#
Referring Pathologist	Phone	Fax	NPI#
Additional reports to	Phone	Fax	NPI#

❹ Billing Information

Payment Options: ☐ Patient Insurance* (If outpatient) ☐ Institution/Client Billing ☐ Split Billing / Medicare* (Pro to Patient, Tech to Client) ☐ Self-Pay

**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.*

If billing insurance: Patient signature required on back. Please attach a copy of face sheet and front/back of card(s).

Primary Insurance			Secondary Insurance		
Subscriber Name	DOB	Relation to Pt	Subscriber Name	DOB	Relation to Pt

❺ Specimen Type

Date obtained:

Time obtained:

- ☐ Amniotic Fluid
- ☐ Chorionic Villi
- ☐ Products of Conception
- ☐ Fetal Tissue

Gestational Age_____

Fetal sex: ☐ Female ☐ Male ☐ Unknown

Fetal sex determined by:
☐ cell-free DNA screen
☐ ultrasound
☐ other

- ☐ Umbilical Cord Blood
- ☐ Peripheral Blood
- ☐ Skin Biopsy (Site_____)
- ☐ Saliva
- ☐ Paraffin Blocks/Slides (Site_____)
- ☐ DNA (Extracted from_____)
- ☐ Other _____

❻ 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 *****

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Legal First Name	MI	Legal Last Name
DOB		

7 Test(s) Requested

☐ **STAT** ☐ ROUTINE

☐ Interphase FISH for
- ☐ Common aneuploidies (13, 18, 21, X, Y)
- ☐ Pregnancy loss (13, 15, 16, 18, 21, 22, X, Y)
- ☐ Monosomy X (X and Y)
- ☐ 22q11.2 deletion (VCFS/DiGeorge) or duplication

☐ Metaphase FISH for
- ☐ 22q11.2 deletion (VCFS/DiGeorge) or duplication
- ☐ SRY (46,XX testicular DSD/46,XY DSD/46,XY CGD)
- ☐ Other (Specify: _____)

☐ Routine chromosome analysis and karyotyping

☐ Mosaicism study by chromosome analysis and karyotyping
- ☐ Mosaicism for _____

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

☐ Grow cell cultures for sendout

Sendout instructions: _____

☐ Chromosomal Microarray Analysis (CMA/CGH/CGAT/SNP Array)
- ☐ Report all findings
- ☐ Do not report variants of uncertain clinical significance

☐ Chromosomal Microarray Analysis, Familial Variant
- ☐ Deletion ☐ Duplication Specify region: _____
- ☐ Results report included, if test done elsewhere

8 Reflex Testing

If _____ is ☐ Normal ☐ Abnormal then reflex to _____

If _____ is ☐ Normal ☐ Abnormal then reflex to _____

If _____ is ☐ Normal ☐ Abnormal then reflex to _____

9 Ordering Provider Signature Required

Submitting a specimen with this requisition form indicates familiarity and agreement with applicable Reference Laboratory Services policies found at ***http://dlmp.uw.edu/patient-care/servicerequest***

Signature	**Date**

10 Patient Insurance Billing Consent

I authorize the Clinical Genomics Laboratory (CGL) 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 CGL. 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.

Signature	**Date**