

FAILURE TO COMPLETE MAY DELAY RESULTS

Patient's Last Name		First	Middle	Birth date (required)	Sex
Outside Patient Number	Outside Specimen Number		Send Report To:		
Ordering Provider			Address:		
Provider Phone Number	DIAGNOSIS / ICD CODE:		Phone/Fax #:		
REQUIRED INFORMATION:					
Healthcare professional to call for information/abnormal results: NAME (please print): _____ PHONE#: _____					

SPECIMEN INFORMATION: Date collected: ____ / ____ / ____
Time collected: _____

Whole Blood: Na Heparin EDTA
 Other (tissue / fibroblast): _____

PERIPHERAL BLOOD
CH-SNP <input type="checkbox"/> Single Nucleotide Polymorphism (SNP) Array
CH-KARY <input type="checkbox"/> Peripheral blood karyotype for _____ <input type="checkbox"/> Peripheral blood karyotype + R/O mosaicism for _____ <input type="checkbox"/> Workup for Turner Syndrome <input type="checkbox"/> Sex determination/ambiguous genitalia (includes 10 metaphase cells by SRY FISH + 20 metaphase cells by G-bands)
CH-FISH <input type="checkbox"/> Fluorescence <i>in situ</i> hybridization (FISH) <input type="checkbox"/> Velocardiofacial (VCF)/DiGeorge Syndrome 22q11.2 deletion/duplication syndrome <input type="checkbox"/> Williams Syndrome <input type="checkbox"/> Other: _____
CH-FAMS <input type="checkbox"/> Family follow-up study (all information is required) Proband name: _____ Relationship to Proband (please provide pedigree): _____ Test indicated on Proband report: <input type="checkbox"/> Limited Karyotype <input type="checkbox"/> FISH <input type="checkbox"/> SNP Array <input type="checkbox"/> qPCR

TISSUE
CH-SKIN <input type="checkbox"/> Solid Tissue - Fibroblast culture ONLY
CH-SKIN <input type="checkbox"/> Solid Tissue - Fibroblast culture + Karyotype
CH-POC <input type="checkbox"/> Tissue - Products of Conception <input type="checkbox"/> SNP Array <input type="checkbox"/> FISH _____ (specify target)
CLINICAL FINDINGS & FAMILY HISTORY
Please include either Diagnosis/ICD-9 Code and/or Clinical Findings for all Cytogenetic testing
_____ _____ _____ (open space for pedigree)

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.

BILL TO:

- Referring Institution (Preferred)** - Provide billing address or stamp institution's information.
(Institutional billing will be done for all patients with Medicare except for established Seattle Children's patients.)

Billing Address:	Billing Contact Name:
Billing Contact Phone/Fax:	Billing Contact Email:

- Primary Insurance** (Attach copy of card.) **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
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	Sex	Subscriber's DOB

- Secondary Insurance** (Attach copy of card.) **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Insurance Company/Medical Coverage		
Claims Address	Phone Number	
Policy Number	Group Number	
Subscriber	Sex	Subscriber's DOB

- Self Pay**- First, call Lab Client Services for pricing. Then, provide credit card information below or enclose a check with the sample.

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		
Name on Credit Card	Payment Amount	CVN
Card Number	Card Type	Expiration

Please visit our test catalog at <http://seattlechildrenslab.testcatalog.org> for testing information or call:
Lab Client Services (206) 987-2617 Cytogenetics Lab (206) 987-3961



Ship to: LABORATORY
4800 Sand Point Way NE, M/S: OC.8.720
SEATTLE, WA 98105