



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		Clinician Signature		Fax	
ICD 10 (Diagnosis)		<small>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.</small>			
Billing: <input type="checkbox"/> Self-pay <input type="checkbox"/> Insurance - Attach copy of card (both side)			Patient is: <input type="checkbox"/> Child <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other (specify)		
Subscriber: Last, First, MI			Primary: carrier & policy number		
Employer			Secondary: carrier & policy number		
Insurance Authorization					
<input type="checkbox"/> Not required or Authorization Number:			Valid Date(s):		

By submitting this requisition, the ordering physician attests:

- All requested laboratory tests are medically necessary
- 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	Results
Collection Date:	Time: AM PM	Collected by:	<input type="checkbox"/>	Physician: _____
<small>For best results, send specimen same day as collection. If necessary to hold specimen overnight, keep at room temp – DO NOT FREEZE.</small>				Call results to: _____
Diagnosis/Indication				Fax results to: _____

Tests Requested

- | | |
|--|---|
| <input type="checkbox"/> Chromosome Analysis, Routine | <input type="checkbox"/> Cell Culture & Cryopreservation - Skin / Tissue only |
| <input type="checkbox"/> Chromosome Analysis, High Resolution | <input type="checkbox"/> FISH, specify _____ |
| <input type="checkbox"/> Microarray Analysis Copy Number + SNP | <input type="checkbox"/> Other test _____ |
| <input type="checkbox"/> qPCR Parent Confirmation | |
| <input type="checkbox"/> qPCR Other Family Member | |

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 _____