



Dept of Pathology & Laboratory Medicine  
 2401 Gillham Rd  
 Kansas City, MO 64108  
 (816) 234-3835

**Prenatal & Pregnancy Loss  
 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)		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.			
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.*

<b>Specimen Information</b>			<b>STAT</b>	<b>Results</b>	
Collection Date:	Time: _____ AM/PM	Collected by:	<input type="checkbox"/>	Physician: _____	
For best results, send specimen same day as collection. If necessary to hold specimen overnight, keep at room temp – DO NOT FREEZE.				Call results to: _____	
<b>Diagnosis/Indication</b>				Fax results to: _____	
<b>Gestation Detail</b>					
GA by U/S: _____ weeks _____ days		Estimated Date of Delivery by U/S: _____			
GA by dates _____ weeks _____ days		Fetal sex: <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> unknown			
<b>PRENATAL</b>					
<b>Specimens Requirements:</b>					
<ul style="list-style-type: none"> <li>Amniotic Fluid: 20-30 mL collected in at least 2 sterile tubes; 30mL if ordering Microarray &amp; chromosomes or FISH together</li> <li>Chorionic Villus Sample (CVS): 50 mg</li> </ul>					
<b>Test Requested:</b>					
<input type="checkbox"/> Chromosome Analysis <input type="checkbox"/> AFAP <input type="checkbox"/> AChE <input type="checkbox"/> FISH Prenatal Panel (13, 18, 21, X & Y) <input type="checkbox"/> Other FISH _____					
<input type="checkbox"/> Targeted Microarray [Maternal blood sample (3mL EDTA) is recommended to rule out maternal cell contamination]					
<input type="checkbox"/> Maternal Cell Contamination <input type="checkbox"/> Other test _____					
<b>Specimen submitted:</b> <input type="checkbox"/> Amniotic Fluid, amount _____ <input type="checkbox"/> CVS amount _____					
<b>PREGNANCY LOSS</b>					
<b>Test Requested:</b>					
<input type="checkbox"/> Chromosome Analysis <input type="checkbox"/> FISH, specify _____					
<input type="checkbox"/> Microarray Analysis [maternal blood sample (3mL EDTA) is recommended to rule out maternal cell contamination]					
<input type="checkbox"/> Maternal Cell Contamination <input type="checkbox"/> Other test _____					
<b>Specimen submitted:</b> <input type="checkbox"/> Fetal Tissue, source _____ <input type="checkbox"/> Villi <input type="checkbox"/> Other _____					