CLEAR FORM

Children's Mercy
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: ☐ Self-pay ☐ Insurance - Attach copy of card (both side) | Patient is: ☐ Child ☐ Self ☐ Spouse ☐ Other (specify) |
|---|---|
| Subscriber: Last, First, MI | Primary: carrier & policy number |
| Employer | Secondary: carrier & policy number |

**Insurance Authorization**
☐ Not required or Authorization Number: Valid Date(s):

By submitting this requisition, the ordering physician attests:

1. All requested laboratory tests are medically necessary
2. **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 |
|---|---|---|---|
| Collection Date: | Time: AM/PM | Collected by: | ☐ |

For best results, send specimen same day as collection.
If necessary to hold specimen overnight, keep at room temp – DO NOT FREEZE.

**Results**
**Physician:** _____
**Call results to:** _____
**Fax results to:**

**Diagnosis/Indication**

**Gestation Detail**
GA by U/S: _____weeks _____days Estimated Date of Delivery by U/S: _____ ☐ donor egg
GA by dates _____weeks _____days Fetal sex: ☐ male ☐ female ☐ unknown ☐ donor sperm

## PRENATAL

**Specimens Requirements:**

- Amniotic Fluid: Chromosome Analysis 10-15 mL; FISH 4 mL; Microarray 10 mL; Alpha Fetal Protein 1 mL
- Chorionic Villus Sample (CVS): 50 mg

**Test Requested:**
☐ Chromosome Analysis ☐ AFAFP ☐ AChE ☐ FISH Prenatal Panel (13, 18, 21, X & Y) ☐ Other FISH _____
☐ Targeted Microarray [Maternal blood sample (3mL EDTA) is recommended to rule out maternal cell contamination]
☐ Maternal Cell Contamination ☐ Other test_____

**Specimen submitted:** ☐ Amniotic Fluid, amount_____ ☐ CVS amount _____

## PREGNANCY LOSS

**Test Requested:**
☐ Chromosome Analysis ☐ FISH, specify_____
☐ Microarray Analysis [maternal blood sample (3mL EDTA) is recommended to rule out maternal cell contamination]
☐ Maternal Cell Contamination ☐ Other test_____

**Specimen submitted:** ☐ Fetal Tissue, source_____ ☐ Villi ☐ Other_____