



**GENETICS LABORATORY  
CYTOGENETICS REQUISITION FORM**

Ship To: O'Donoghue Research Bldg.  
1122 NE 13 Street, Suite 1400  
Oklahoma City, OK 73104  
Phone: 405-271-3589  
Fax: 405-271-7117  
After hours phone: 405-496-9514

Page 1 of 2  
PLEASE COMPLETE ALL FORMS AND SEND  
WITH PATIENT SAMPLE

Courier Service in OKC metro area call  
Rapid Transit 793-1122 for specimen pickup

**REFERRING PHYSICIAN/FACILITY** **PATIENT AND BILLING INFORMATION**

Physician Name \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone(\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_  
Genetic Counselor \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_  
Laboratory/Institution \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone(\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Patient Name (last,first,m.) \_\_\_\_\_  
Parent Name (if patient is a minor) \_\_\_\_\_  
DOB \_\_\_\_\_ SSN \_\_\_\_\_ MRN \_\_\_\_\_  
**Sex:**  Male  Female  Ambiguous  Unknown  Inpatient  Outpatient  
Ethnicity of patient (check all that apply)  
 African-American  Asian  Caucasian/NW European  E. Indian  
 Hispanic  Jewish-Ashkenazi  Jewish-Sephardic  Native American  
 Native Hawaiian/Other Pacific Islander  Other \_\_\_\_\_  
Patient's Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**SPECIMEN/CLINICAL INFORMATION**

**Diagnosis/Clinical Findings/Family History** \_\_\_\_\_  
You may also list ICD-10 codes \_\_\_\_\_ Date Specimen Collected \_\_\_\_\_ Time \_\_\_\_\_

**SPECIMEN TYPES & COLLECTION REQUIREMENTS** **TEST INFORMATION**

**Peripheral Blood**  **Cord Blood**  **Pellet** previous lab # \_\_\_\_\_  
3-5 cc in large sodium heparin tube (dark green top), mix well. Keep specimen at room temperature or cooler, do not freeze. No additional blood needed for FISH

**Amniotic Fluid**  **CVS**  **Fetal Urine**  
**DO NOT TRANSPORT SPECIMENS IN SYRINGES!**  
Collect 15-20 cc and transfer to sterile centrifuge tubes. For FISH studies an additional 5 cc of fluid is required. Keep specimen cool but do not freeze.  
**Gestational age by:** ultrasound \_\_\_\_\_ or LMP \_\_\_\_\_  
Gravida \_\_\_ Para \_\_\_\_\_

**Skin Biopsy**  **Products of Conception**  **Placenta**  **Fetal Tissue**  
2-3 cc/1-2cm<sup>2</sup> in transport media or sterile normal saline. Do not use formalin and do not use a fixative. Observe sterile technique. Keep cool, do not freeze

**Unstained Slides (FISH testing only)**

**Buccal swab (FISH testing only)** Collect 2 specimens w/nylon brushes. Keep fresh sample at room temperature.

**Test Type**  
 **Karyotype** (routine chromosome analysis)  
 **Karyotype and FISH** Select a FISH probe  
 **FISH only** Select a FISH probe If previous chromosome studies have been done, provide a copy of these results if performed at another lab.  
 **Culture only** \_\_\_\_\_

**FISH Probes**  
 Trisomy of \_\_\_\_\_  
 Screen for trisomies of 13, 18, 21, X and Y  
 1p36 deletion syndrome  
 Angelman syndrome  CHARGE syndrome  
 Cri-du-Chat syndrome  DiGeorge syndrome 22q11.2  
 Kallmann syndrome  Klinefelter syndrome  
 Miller-Dieker syndrome  Prader-Willi syndrome  
 Smith-Magenis syndrome  Sex chromosomes  
 Sotos syndrome  SRY gene deletion  
 Turner syndrome  Williams syndrome  
 Wolf-Hirschorn syndrome

**\* If you would like to order a molecular, sequencing, or cancer test please refer to the correct requisition forms. This is not the correct form to order those tests.**

**ADDITIONAL REPORT** **GENETICS LABORATORY USE ONLY**

Physician/Facility \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_

Laboratory Number \_\_\_\_\_  
Date & Time of Pick-Up/Delivery \_\_\_\_\_  
Location \_\_\_\_\_  
Initials \_\_\_\_\_ Check-in \_\_\_\_\_  
Additional Specimen(s) sent for this patient \_\_\_\_\_  
Previous Lab Number \_\_\_\_\_



## BILLING INFORMATION FORM

PLEASE NOTE: YOU MUST CHOOSE ONE OF THE THREE BILLING OPTIONS LISTED BELOW.  
PLEASE FORWARD ALL BILLING QUESTIONS TO DOTIS@OUHSC.EDU

## PATIENT INFORMATION

Patient Name (LAST, FIRST, MI) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ PATIENT DATE OF BIRTH: \_\_\_\_\_

## PAYMENT OPTION 1-INSTITUTION

INSTITUTION NAME: \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_ CONTACT NAME: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

FAX NUMBER: \_\_\_\_\_

## PAYMENT OPTION 2-SELF PAY (PAYMENT MUST BE SENT WITH SAMPLE)

 CREDIT CARD (CIRCLE ONE): AMEX DISCOVER VISA MASTERCARD AMOUNT TO CHARGE: \_\_\_\_\_

VALID CARD # \_\_\_\_\_ EXP DATE \_\_\_\_\_

CVC CODE: \_\_\_\_\_ CARDHOLDER PRINTED NAME: \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

CARDHOLDER SIGNATURE: \_\_\_\_\_

 CHECK CHECK # \_\_\_\_\_ AMOUNT ENCLOSED: \_\_\_\_\_

## PAYMENT OPTION 3-INSURANCE PROVIDE A LEGIBLE COPY OF THE FRONT &amp; BACK OF INSURANCE CARD!

POLICYHOLDER NAME: \_\_\_\_\_ POLICY HOLDER DOB: \_\_\_\_\_

POLICYHOLDER SS# \_\_\_\_\_ GENDER: M F

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURANCE CO. NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

CLAIMS ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_

I AUTHORIZE UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY TO FURNISH ANY MEDICAL INFORMATION REQUESTED ON MYSELF, OR MY COVERED DEPENDENTS. IN CONSIDERATION OF SERVICES RENDERED, I TRANSFER AND ASSIGN ANY BENEFITS OF INSURANCE TO UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY. I UNDERSTAND I AM RESPONSIBLE FOR ANY CO-PAY, DEDUCTIBLES, OR NON-AUTHORIZED SERVICES AND REMAINING BALANCES AFTER INSURANCE REIMBURSEMENT. I UNDERSTAND I AM FULLY RESPONSIBLE FOR PAYMENT OF MY ACCOUNT IF THE UNIVERSITY OF OKLAHOMA HSC GENETICS LABORATORY IS NOT A PARTICIPANT WITH MY HEALTH PLAN, AND MY HEALTH PLAN DOES NOT FULLY REIMBURSE MY MEDICAL SERVICES DUE TO LACK OF AUTHORIZATION OR MEDICAL NECESSITY.

PRINTED NAME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_