THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

GENETICS LABORATORY
MOLECULAR REQUISITION FORM

PLEASE COMPLETE ALL FORMS AND SEND WITH PATIENT SAMPLE

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
www.genetics.ouhsc.edu

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

REFERRING PHYSICIAN/FACILITY

Physician Name _____

NPI_____

Phone (____)_____ Fax(___)_____

Genetic Counselor_____Phone (____)_____

Laboratory/Institution_____

Phone (___)_____ Fax (____)_____

Address _____

City _____ State_____ Zip_____

Phone (____)_____ Fax (____)_____

PATIENT AND BILLING INFORMATION

Patient Name (last,first,m.)_____

Parent Name (if pt 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-9 codes

Date Specimen Collected_____ Time_____

SPECIMEN TYPES & COLLECTION REQUIREMENTS

□ **Peripheral Blood**
3-5 cc in a large EDTA tube (purple top),mix well. Specimen must be kept at room temperature or cooler, do not freeze.

□ **Amniotic Fluid Do Not Transport Specimen in Syringes!**
Collect 5-10 cc of fluid and transfer to sterile centrifuge tubes. Keep specimen cool but do not freeze. **Gestational age by:**
ultrasound_____ or LMP_____
Gravida__ __ Para__ __ __ __

□ **Isolated DNA**
Contact laboratory to obtain concentration and volumes that are required. DNA isolation must have taken place in a CLIA-certified laboratory or a lab meeting equivalent requirements as determined by CAP and/or CMS.

TEST INFORMATION

Please Select One of the Following Studies:
□ Angelman syndrome (methylation)
□ Beckwith Wiedemann/Russell Silver syndromes
□ CGH Microarray
□ Cystic Fibrosis (137 mutation panel)
□ Fragile X (PCR/Southern blot)
□ Huntington Disease (PCR/Southern blot)
□ Hypotonia Panel (PWS, SMN1, DMPK assays performed)
□ Myotonic Dystrophy *DMPK* gene (PCR)
□ Prader Willi syndrome (methylation)
□ Sickle Cell disease
□ SNP Microarray
□ Spinal Muscular Atrophy *SMN1/2* (exon 7 deletion)
□ Y chromosome deletion

□ Uniparental disomy (UPD) chromosome_____
(For this test collect blood from both biological parents and child)

ADDITIONAL REPORT

Physician/Facility_____

Phone_(___)_____ Fax_(___)_____

Address_____

_____

8/2018

GENETICS LABORATORY USE ONLY

Laboratory Number_____

Date & Time of Pick-Up/Delivery_____

Location_____

Initials_____ Check-in_____

Additional Specimen(s)sent for patient_____

Previous Lab Number_____

THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

Genetics Laboratory
Billing Information Form

Patient Name LAST_____ FIRST_____ MI_____

YOU MUST CHOOSE ONE OF THE THREE BILLING OPTIONS LISTED BELOW.
PLEASE FORWARD ALL BILLING QUESTIONS TO DANIELLE OTIS AT DOTIS@OUHSC.EDU OR CALL 405-271-3589 OPT 4
AT THIS TIME WE DO NOT ACCEPT OUT-OF-STATE MEDICAID

PAYMENT OPTION 1-INSTITUTION

INSTITUTION NAME _____

BILLING ADDRESS_____

CITY, STATE, ZIP _____ CONTACT NAME_____

PHONE NUMBER_____ FAX NUMBER_____ CONTACT EMAIL ADDRESS _____

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_____

CVV CODE _____ CARDHOLDER PRINTED NAME_____

BILLING ADDRESS _____ CITY, STATE, ZIP_____

CARDHOLDER SIGNATURE _____

☐ **CHECK #** _____ AMOUNT ENCLOSED_____

PAYMENT OPTION 3-INSURANCE PROVIDE A LEGIBLE COPY OF THE FRONT & BACK OF INSURANCE CARD
PLEASE NOTE: OUR FACILITY WILL CONFIRM COVERAGE AND VERIFY WHETHER OR NOT THE TEST(S) ORDERED ARE COVERED BY YOUR PLAN.
OUR OFFICE CAN ALSO OBTAIN PRE-AUTHORIZATION FROM THE INSURANCE PLAN.

PRIMARY INSURANCE POLICYHOLDER NAME _____ POLICYHOLDER DOB_____

PRIMARY POLICYHOLDER SS# _____ GENDER:○M ○F EMPLOYER_____

RELATIONSHIP TO PATIENT_____ POLICY # _____

GROUP #_____ INSURANCE CO. NAME _____

PHONE _____ CLAIMS ADDRESS _____

CITY, STATE, ZIP_____ INSURANCE AUTH #_____

SECONDARY INSURANCE POLICYHOLDER NAME _____ POLICYHOLDER DOB_____

SECONDARY POLICYHOLDER SS# _____ GENDER:○ M ⊙ F EMPLOYER_____

RELATIONSHIP TO PATIENT_____ POLICY # _____

GROUP #_____ INSURANCE CO. NAME _____

PHONE _____ CLAIMS ADDRESS _____

CITY, STATE, ZIP_____ INSURANCE AUTH #_____

I CONSENT TO HAVE THE TEST(S) LISTED ON THE PREVIOUS PAGE PERFORMED. I AUTHORIZE THE 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 OR MY HEALTH PLAN DOES NOT FULLY REIMBURSE MY MEDICAL SERVICES DUE TO LACK OF AUTHORIZATION OR MEDICAL NECESSITY.

PRINTED NAME _____ SIGNATURE_____ DATE _____