

**CYTOGENETICS LABORATORY TEST REQUISITION** 411-002E front / 11-09

PATIENT / SPECIMEN INFORMATION				
PATIENT NAME - LAST, FIRST, MI		<input type="checkbox"/> M <input type="checkbox"/> F	SSN OR MRN	DATE OF BIRTH
RACE	DIAGNOSIS - INDICATIONS FOR TESTING			
ICD9	SPECIMEN TYPE	COLLECTION DATE	TIME	
REFERRAL SOURCE				
REQUESTING / CONTACT PHYSICIAN		PHONE NUMBER	FAX NUMBER	
PHYSICIAN ADDRESS, CITY, STATE, ZIP CODE			FAX RESULTS <input type="checkbox"/> Yes <input type="checkbox"/> No	
REFERRING FACILITY		PHONE NUMBER	FAX NUMBER	
FACILITY ADDRESS, CITY, STATE, ZIP - IF DIFFERENT FROM ABOVE			FAX RESULTS <input type="checkbox"/> Yes <input type="checkbox"/> No	
ADDITIONAL REPORTS TO				

CYTOGENETIC TESTS			
CHROMOSOME ANALYSIS		MICROARRAY ANALYSIS	
Amniotic Fluid	Chromosome Array (aCGH)	IGH / BCL2	14;18 translocation
Blood - Routine	Parental Studies (aCGH)	IGH / CCND1	11;14 translocation
Blood - High Resolution	(specify family member)	IGH rearrangements	14q32
Blood - for Leukemic Study		MLL rearrangements	11q23
Blood - Mosaicism		PML / RARA	15;17 translocation
Bone Marrow		TEL / AML1	12;21 translocation
Lymph Node		XX / XY	Opposite sex BMT
Placenta		<b>Microdeletion Syndromes</b>	
Products of Conception	<b>FISH TESTS</b>		Angelman Syndrome
	Aneuvysion (Prenatal 13, 18, 21, X & Y)		Cri-du-Chat Syndrome
Skin	Aneuploidy (Newborn 13, 18, 21, X & Y)		Deletion 22q / DiGeorge / VCF Syndrome
Skin - Mosaicism	<b>Breast Cancer</b>		Kallman Syndrome
Solid Tumor	HER-2 / neu		Miller-Dieker Syndrome
<b>CELL CULTURE ONLY</b>		<b>Hematologic Malignancies</b>	Prader-Willi Syndrome
Amniotic Fluid	<b>Panels</b>		Smith-Magenis Syndrome
Blood	ALL profile		Williams Syndrome
Bone Marrow	AML/MDS profile		Wolf-Hirschhorn Syndrome
Products of Conception	CLL profile		<b>Sex Chromosomes</b>
Skin or Solid Tissue	Multiple myeloma profile		SRY gene / X chromosome
Freezing of Cultured Cells	AML1 / ETO	8;21 translocation	X and Y chromosomes
Retrieval / Culture of Frozen Cells	BCR / ABL	9;22 translocation	<b>OTHER (specify)</b>
<b>OTHER PRENATAL TESTS</b>		CBFB	Inversion 16
Acetylcholinesterase (AChE)	Chromosomes 4, 10, 17 enumeration		
Alpha-Fetoprotein (AF-AFP)	Chromosome 5 enumeration		
Other (specify)	Chromosome 7 enumeration		
	Chromosome 8 enumeration		

CENTER FOR GENETIC TESTING AT SAINT FRANCIS USE ONLY			
DATE RECEIVED	TIME	TYPE / AMOUNT RECEIVED	ACCESSION NUMBER
CASE NUMBER	PATIENT NUMBER	INVOICE NUMBER	AUTHORIZATION NUMBER

**Saint Francis** Health System Center for Genetic Testing at Saint Francis

Saint Francis Laboratory • 6161 South Yale Avenue • Tulsa, OK 74136  
 (918) 502-1720 Phone • (918) 502-1723 Fax • (866) 846-0315 Toll Free  
 www.saintfrancisgenetics.com

**BILLING INFORMATION** 411-002E back / 11-09

**PAYMENT INFORMATION - INDICATE ONE**

**SELF PAY (Payment in Full from Patient or Guarantor)**

Check or Money Order

<input type="checkbox"/> Credit Card <input type="checkbox"/> VISA <input type="checkbox"/> MC <input type="checkbox"/> OTHER			CARDHOLDER NAME - PRINT	ZIP CODE
ACCOUNT NUMBER	EXPIRATION DATE	SECURITY NO.	CARDHOLDER - SIGNATURE	

**Payment for Medical Care:** It is understood and agreed that the undersigned or a designated agent will be responsible and assume an obligation to pay the Center for Genetic Testing at Saint Francis all costs for genetic evaluation and testing rendered to the person whose name appears within thirty (30) days after having been notified of the amount due and owing or will work out a satisfactory payment plan with the Center for Genetic Testing at Saint Francis. It is further understood and agreed that the undersigned or designated agent will, at all times, remain responsible for the costs of said genetic evaluation and testing.

PATIENT SIGNATURE - MUST BE 18 YEARS OR OLDER TO SIGN \_\_\_\_\_ DATE \_\_\_\_\_

PARENT / LEGAL GUARDIAN - REQUIRED IF PATIENT IS LESS THAN 18 YEARS OF AGE OR IS NOT LEGALLY COMPETENT \_\_\_\_\_

ADDRESS, CITY, STATE, ZIP \_\_\_\_\_ HOME PHONE NUMBER \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE NUMBER \_\_\_\_\_

WITNESS - SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**INSURANCE (Filed as Courtesy - Patient Ultimately Responsible for Balance of Account)**  
**FRONT AND BACK COPY OF CARD, REFERRAL NUMBER (HMO), REFERRAL DATE AND AUTHORIZATION REQUIRED FOR THIRD PARTY BILLING**

INSURED NAME		INSURED SOCIAL SECURITY NUMBER	INSURED DATE OF BIRTH
PRIMARY CARE PHYSICIAN		EMPLOYER	
INSURANCE COMPANY NAME	INSURANCE COMPANY PHONE	POLICY NUMBER	GROUP NUMBER
INSURANCE COMPANY ADDRESS, CITY, STATE, ZIP CODE			
REFERRAL NUMBER	REFERRAL DATE	EFFECTIVE DATE	AUTHORIZATION NUMBER
MEDICARE NUMBER		MEDICAID NUMBER (OKLAHOMA ONLY)	

**Authorization to Release Protected Health Information, Assign Benefits, and Accept Responsibility for My Account:** I authorize any physician or laboratory who has treated me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I transfer and assign any benefits of insurance to Center for Genetic Testing at Saint Francis. I understand that I am responsible for any co-pay or deductible amounts if the Center for Genetic Testing at Saint Francis is a participant in my health plan. I understand I am fully responsible for payment of my account if the Center for Genetic Testing at Saint Francis is not a participant with my health plan, and my health plan does not reimburse (or only partially reimburses) my medical services due to lack of authorization or medical necessity. **The information permitted for release may include records which indicate the presence of a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS), and/or mental health information.**

PATIENT / GUARANTOR - SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**REFERRING FACILITY**

FACILITY NAME	PHONE NUMBER	FAX NUMBER
BILLING ADDRESS	APPROVAL NUMBER - IF APPLICABLE	

**OSDH**

AUTHORIZATION NUMBER \_\_\_\_\_