

CYTOGENETICS LABORATORY TEST REQUISITION 411-002F front / 01-11

| 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 | | REQUESTING PHYSICIAN / PRACTITIONER SIGNATURE - (REQUIRED BY MEDICARE) | |
| PHYSICIAN ADDRESS, CITY, STATE, ZIP CODE | | PHONE NUMBER | FAX RESULTS FAX NUMBER <input type="checkbox"/> No <input type="checkbox"/> Yes |
| REFERRING FACILITY | | | |
| FACILITY ADDRESS, CITY, STATE, ZIP - IF DIFFERENT FROM ABOVE | | PHONE NUMBER | FAX RESULTS FAX NUMBER <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 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 | | Microdeletion Syndromes | |
| Products of Conception | FISH TESTS | Angelman Syndrome | |
| Skin | Aneuvysion (Prenatal 13, 18, 21, X & Y) | Cri-du-Chat Syndrome | |
| Skin - Mosaicism | Aneuploidy (Newborn 13, 18, 21, X & Y) | Deletion 22q / DiGeorge / VCF Syndrome | |
| Solid Tumor | Breast Cancer | Kallman Syndrome | |
| | HER-2 / neu | Miller-Dieker Syndrome | |
| CELL CULTURE ONLY | Hematologic Malignancies | Prader-Willi Syndrome | |
| Amniotic Fluid | Panels | Smith-Magenis Syndrome | |
| Blood | ALL profile | Williams Syndrome | |
| Bone Marrow | AML/MDS profile | Wolf-Hirschhorn Syndrome | |
| Products of Conception | CLL profile | Sex Chromosomes | |
| 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 | OTHER (specify) | |
| OTHER PRENATAL TESTS | 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 411-002F back / 01-11

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 _____