

BIOCHEMICAL GENETICS LABORATORY TEST REQUISITION 411-006A front / 01-08

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	CONSENT OBTAINED <input type="checkbox"/> Yes <input type="checkbox"/> No
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				

BIOCHEMICAL GENETICS TESTS		
ROUTINE TESTS	OTHER GENETIC TESTS	OTHER GENETIC TESTS (continued)
Acetoacetate	7-Dehydrocholesterol, Plasma-Quantitative	Orotic Acid/Orotidine, Urine-Quantitative
Acylcarnitine Profile, Plasma-Quantitative	Amino Acids, Amniotic Fluid-Quantitative	Pipecolic Acid - Serum/Urine
Amino Acids, Plasma-Quantitative	Amino Acids, CSF-Quantitative	Plasmalogens
Amino Acids, Urine-Quantitative	Biopterin/Neopterin	Purine/Pyrimidine Panel, Urine
Basic Meta (Basic Metabolic Panel)	Biotinidase, Serum	Pyruvate Kinase in RBC
Beta Hydroxybutyric Acid (BHB)	Creatine/Guanidinoacetate Analysis, Plasma	S-Sulfocystine
Carnitine Determination, Plasma-Quantitative	Creatine/Guanidinoacetate Analysis, Urine	Sulfatide, urine
Carnitine Level, Urine	Cystine in White Blood Cells, Quantitative	Sterols, Plasma
CBC w plt & diff	Erythrocyte Membrane Lipid Fatty Profile	Succinylacetone, Urine - Quantitative
Cholesterol	Fatty Acid Profile (essential)	Tay Sachs Carrier Testing
CK	Galactitol	Transferrin Electroph, serum (Isoelec focusing)
Comp Meta (Comprehensive Metabolic Panel)	Galactokinase	Very Long Chain Fatty Acid (VLCFA)
Lactate	Galactose -1- phosphate RBC	STORAGE DISORDERS
LDH	Galactose -1- phosphate uridytransferase	Lysosomal Enzyme Screen
Organic Acid, Urine-Quantitative	Galactose 4 UPD Epimerase	Mucopolysaccharide Screen, Urine-Qualitative/Quantitative
Phenylalanine Determination, Plasma-Quantitative	Glycine, CSF	Oligosaccharide Screen, Urine-Qualitative
Phenylalanine/Tyrosine, Plasma/Blood spot-Quantitative	Hemoglobin Electrophoresis	HEMOLYTIC ANEMIA
Phosphorase	Homocysteine, Plasma-Quantitative	G6PD quantification, RBC
Pyruvate	Methylmalonic Acid, Plasma-Quantitative	Hexokinase, RBC
Supplemental Newborn Screening, blood spot	Mitochondrial Respiratory Chain	Pyruvate Kinase in RBC
Trig	Mitochondrial Respiratory Chain Enzymes - Skin Fibroblasts	
Uric Acid	MSUD profile, plasma	
Urinalysis	N-acetylaspartate (Canavan)	

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 411-006A back / 01-08

PAYMENT INFORMATION - INDICATE ONE

SELF PAY (Payment in Full from Patient or Guarantor)

Check or Money Order

OTHER

Credit Card VISA MC

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

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EMPLOYER

WORK PHONE NUMBER

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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

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BILLING ADDRESS

APPROVAL NUMBER - IF APPLICABLE

OSDH

AUTHORIZATION NUMBER