

**BIOCHEMICAL GENETICS LABORATORY TEST REQUISITION** 411-006C / 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			
ICD9	SPECIMEN TYPE	COLLECTION DATE	TIME	
REFERRAL SOURCE				
REQUESTING PHYSICIAN		REQUESTING PHYSICIAN / PRACTITIONER SIGNATURE - (REQUIRED BY MEDICARE)		
PHYSICIAN ADDRESS, CITY, STATE, ZIP CODE		PHONE NUMBER	FAX RESULTS <b>FAX</b> NUMBER <input type="checkbox"/> No <input type="checkbox"/> Yes	
REFERRING FACILITY				
FACILITY ADDRESS, CITY, STATE, ZIP - IF DIFFERENT FROM ABOVE		PHONE NUMBER	FAX RESULTS <b>FAX</b> NUMBER <input type="checkbox"/> No <input type="checkbox"/> Yes	
ADDITIONAL REPORTS TO				

BIOCHEMICAL GENETICS TESTS		
TEST LIST	SPECIMEN REQUIREMENTS	
ACYLCARNITINE PROFILE, PLASMA-QUANTITATIVE	1.0 ML WHOLE BLOOD-NA HEPARIN	
AMINO ACIDS, PLASMA-QUANTITATIVE	2.0 ML WHOLE BLOOD-NA HEPARIN	
AMINO ACIDS, URINE-QUANTITATIVE	3.0 ML URINE	
AMINO ACIDS, CSF-QUANTITATIVE	0.5 ML CSF	
CARNITINE (TOTAL AND FREE), PLASMA-QUANTITATIVE	2.0 ML WHOLE BLOOD-NA HEPARIN	
ORGANIC ACID, URINE-QUALITATIVE	3.0 ML URINE-VACUETTE URINE CONTAINER	
25-HYDROXY VITAMIN D TOTAL (WITH D2 AND D3)	2.0 ML WHOLE BLOOD-GOLD TOP SST OR RED TOP	
PKU MANAGEMENT (PHE AND TYR BY LC/MSMS)	FILTER PAPER BLOOD SPOTS (MIN 2 BLOOD SPOTS/CARD)	
SUPPLEMENTAL NEWBORN SCREEN BY LC/MSMS	FILTER PAPER BLOOD SPOTS (MIN 2 BLOOD SPOTS/CARD)	
<b>PROCEDURAL NOTES</b>		
WHOLE BLOOD AND CSF SPECIMENS		
• CENTRIFUGE SPECIMEN		
• SEPARATE PLASMA, SERUM, CSF		
• ALIQUOT SPECIMEN INTO POLYPROPYLENE TEST TUBE		
• FREEZE ALIQUOTTED SPECIMEN		
• SHIP FROZEN SPECIMEN ON DRY ICE		
URINE SPECIMEN		
• ALIQUOT 3.0 ML OF URINE INTO VACUETTE TEST TUBE		
• FREEZE ALIQUOTTED URINE SPECIMEN		
• SHIP FROZEN URINE SPECIMEN ON DRY ICE		
<b>RESULTS</b>		
ALLOW 3-7 DAYS FOR SPECIMEN DELIVERY, PROCESSING AND RESULT INTERPRETATION		

CENTER FOR GENETIC TESTING AT SAINT FRANCIS USE ONLY			
DATE RECEIVED	TIME	AMOUNT RECEIVED	ACCESSION NUMBER

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

Saint Francis Laboratory • 6161 South Yale Avenue • Tulsa, OK 74136  
 (918) 502-2290 Phone • (918) 502-2292 Fax • (866) 846-0315 Toll Free  
 www.saintfrancisgenetics.com

**BILLING INFORMATION** 411-006C back / 01-11

**PAYMENT INFORMATION - INDICATE ONE**

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

Check or Money Order

OTHER

CARDHOLDER NAME - PRINT

ZIP CODE

Credit Card

VISA

MC

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