

CYTOGENETICS LABORATORY TEST REQUISITION 411-002B front / 10-04

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	
<input checked="" type="checkbox"/>	CHROMOSOME ANALYSIS
	Amniotic Fluid
	Blood - Routine
	Blood - High Resolution
	Products of Conception
	Skin
<input checked="" type="checkbox"/>	NEOPLASTIC
	Bone Marrow
	Blood - for Leukemic Study
	Solid Tumor
<input checked="" type="checkbox"/>	SPECIALIZED STUDIES
	Fanconi Anemia (DEB) - Blood
	Mosaicism - Blood
	Mosaicism - Skin
	Special Staining (CBG, NOR)
<input checked="" type="checkbox"/>	CELL CULTURE
	Amniotic Fluid
	Blood
	Bone Marrow
	Skin or Solid Tissue
	Freezing of Cell Line
	Retrieval / Culture of Frozen Cell Line
<input checked="" type="checkbox"/>	FISH TESTS
	Aneuvysion (Prenatal 13, 18, 21, X & Y)
	Angelman Syndrome
	Cri-du-Chat Syndrome
	DiGeorge Syndrome
	BCR/ABL
	Kallman Syndrome
	Miller-Dieker Syndrome
	Prader-Willi Syndrome
	Smith-Magenis Syndrome
	Velocardiofacial Syndrome
	Williams Syndrome
	Wolf-Hirschhorn Syndrome
	Other (specify)
<input checked="" type="checkbox"/>	PRENATAL BIOCHEMICAL TESTS
	Acetylcholinesterase
	Amniotic Fluid Alpha-Fetoprotein (AF-AFP)
	Fetal Hemoglobin
	Maternal Serum AFP / free-β hCG (double screen)
	Maternal Serum AFP / free-β hCG estriol (triple screen)
	Other (specify)

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 411-002B back / 10-04

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	ACCOUNT NUMBER	EXPIRATION DATE
CARDHOLDER NAME - PRINT				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
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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
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REFERRING FACILITY

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

OSDH

AUTHORIZATION NUMBER
