C. TEST SELECTION

- Chromosome Analysis
- Chromosome Breakage for Fanconi anemia
  * call our laboratory when shipping a sample for this test - advance preparations are helpful for analysis.
- FISH - Aneuploidy [13, 18, 21, X, Y]
- FISH - 22q11.2
- FISH - [specify]:
- Fragile X *performed & reported by Nebraska Medicine Molecular Diagnostic Lab
- Male Infertility PANEL [includes both tests listed below]
  - Chromosome Analysis ONLY
  - Y Chromosome Microdeletion (YCMD) ONLY
- Methylation Analysis* - Chromosome 14
  [Temple syndrome (Prader-Willi-like), Paternal UPD 14]
- Methylation Analysis* - Chromosome 15
  [Prader-Willi syndrome, Angelman syndrome]
  *Microarray studies are recommended in conjunction with methylation analysis
- Microarray Analysis - High Density SNP with confirmatory studies, if needed

OTHER TESTING
- Cell Culture and Cryopreservation only
- DNA Extraction and Cryopreservation only
- Other - [specify]:

D. CLINICAL INFORMATION

- Attach family history, pedigree, or other clinical information, if available

ANCESTRY / FAMILY HISTORY:
- African American
- Asian
- Latin American/Caribbean
- Native American
- European
- Other:

CLINICAL INFORMATION:

INDICATIONS FOR TESTING:
POSTNATAL Test Request Form

NAME: ___________________________ DOB: ___________ MR#: ___________________________ BIOLOGICAL SEX:  □ Female  □ Male

INSURANCE / PATIENT BILLING  › Requires patient signed statement of responsibility, below.

- Include an enlarged copy of both sides of the insurance card; Call 402-559-5710 with authorization questions.
- Medicaid  □ Medicaid pending  □ Medicare » An ABN may be required
- Insurance approved: AUTH#: ___________________________ VALID DATE: ___________ EXP DATE: ___________
- Preauthorization service requested (testing will be placed on hold until authorization is complete)
  › Provide patient contact info - PHONE#: ___________________________ EMAIL: ___________________________

ICD CODE(S):
- Patient insurance  » If policy holder is different from patient, provide:
  □ Self-pay (patient billed after testing is completed) NAME: ___________________________ DOB: ___________
  □ Pre-pay (testing begins once full payment is made) RESPONSIBLE PARTY NAME: ___________________________

STATEMENT OF FINANCIAL RESPONSIBILITY - My signature below indicates that I understand that I am accepting financial responsibility for all fees associated with this genetic testing including but not limited to co-pays, co-insurance, and unmet deductibles that the insurance policy dictates. I understand that I may also be responsible for any amounts not paid by my insurance carrier for reasons including but not limited to non-covered and non-authorized services. I authorize the Human Genetics Laboratory to provide my insurance carrier any information necessary for processing my insurance claim, including but not limited to test results.

Required for insurance and patient billing - Signature of responsible party: ___________________________ Date: ___________

STATEMENT OF MEDICAL NECESSITY - The test(s) ordered is medically necessary for the diagnosis of this patient's condition. The results from this testing will guide medical management and determine treatment decisions for this patient. As the ordering provider, I am legally authorized to request this testing. I have provided the patient with the testing information and the patient has provided informed consent to the testing I have ordered. The patient / patient's family have been counseled regarding the implications of receiving secondary findings. I explained the potential benefits and limitations of receiving secondary findings and have answered their questions. I do hereby attest that this information is true, accurate, and complete to the best of my knowledge.

Signature of ordering provider (signed clinic notes will be accepted in lieu of a provider signature) ___________________________ Date: ___________

ORDERING PROVIDER

NAME: ___________________________
FACILITY
NAME: ___________________________
ADDRESS: ___________________________
PHONE: ___________________________ FAX: ___________________________
EMAIL: ___________________________

SEND ADDITIONAL REPORT COPY TO

NAME: ___________________________
FACILITY
NAME: ___________________________
ADDRESS: ___________________________
PHONE: ___________________________ FAX: ___________________________
EMAIL: ___________________________

G. SHIPPING  › Shipping supplies (collection kits, tubes, transport media, prepaid airbills) are available to our clients upon request.

LOCAL TRANSPORT:  Call the laboratory (402-559-5070) to request specimen pickup.

OUT OF AREA TRANSPORT:  Prior to shipping please fax this form to 402-559-7248 » include shipment tracking # in space provided below

• Shipping Address:  Human Genetics Laboratory - Zip 5440  /  UNMC Shipping & Receiving Dock / 601 S Saddle Creek Road / Omaha NE 68106
• Include Shipment Tracking Information »