Knight Diagnostic Laboratories

Fax: (855) 535-1329
Email: KDLClientServices@ohsu.edu
Shipping: 2525 SW 3rd Ave, Ste 350, Portland, OR 97201
Questions? (855) 535-1522

Constitutional/Prenatal Cytogenetics Requisition

Patient Information

Patient Last Name

Patient First Name

Street Address

City, State, Zip

Phone DOB / /

Fax Male Female

ID/MRN #

Hospital In-Patient Yes No

Physician Signature Date

Ordering Healthcare Provider Information

Full Name

NPI

Office/Facility Name

Address

City, State, Zip

Phone Fax

Account #

Notes

Send additional copies of test results to:

Healthcare Provider Name Provider Phone Fax

Healthcare Provider Name Provider Phone Fax

Billing Information - Select One Billing Method

Billing is done in accordance with the information provided below and OHSU policy. Appropriate areas must be completed or referring laboratory/physician will be billed.

Self Pay

Bill Insurance
Attach Copy of Insurance Card or Billing Face Sheet

Bill Referring Provider or Institution
Invoice will be sent to Client Account and Address Listed Above

Primary Insurance Name

Primary Policy #

Primary Group #

Preauthorization #

Relation to Insured Medicaid Medicare

Self Child Spouse Other____________________

Secondary Insurance Name

Secondary Policy #

Secondary Group #

Preauthorization #

Relation to Insured Medicaid Medicare

Self Child Spouse Other____________________

Clinical Information

Specimen Type

- ☐ Amniotic Fluid
- ☐ Blood, EDTA
- ☐ Blood, Sodium Heparin
- ☐ CVS
- ☐ Fibroblasts
- ☐ Skin Biopsy
- ☐ Other________________________

Date of Collection:

Time of Collection:

Pregnancy History	
G:	TAB:
P:	SAB:
Gestational Age:	
Determined By:	
WBC:	

NOTICE REGARDING PRENATAL TESTING

Maternal cell rule-out testing may be performed on all prenatal specimens received. Please provide maternal blood or saliva in addition to the fetal specimen. Additional charges apply for the maternal cell rule-out test.

Clinical Information Continued

ICD-10 (required)

Required: Reason for Referral Description (fetal abnormalities, provisional diagnosis, family history of chromsome abnormalites, etc):

Maternal Cell Rule Out

****If the maternal sample is from someone other than the patient named above, a separate requisition with the mother's information is required****

1980 Maternal Cell Rule Out	Date of Collection: Time of Collection:
Maternal Cell Rule Out Sample:	
Blood, EDTA	
Blood, ACD	
Saliva	

*Chromosome Assays/Molecular Genetic Tests

Code	Test Name	Code	Test Name
6020	Amniotic Fluid: Full Chromosome Analysis	6754	Solid Tissue/Fibroblasts (includes POC): Full Chromosome Study reflexed to FISH
6054	Blood: High Resolution Chromosome Study reflexed to FISH	6500	Chromosomal Microarray
6078	Breakage Analysis: Blood Chromosome Study	6510	**Chromosomal Microarray - Prenatal Diagnosis
6080	Breakage Analysis: Skin Chromosome Study	N/A	**Prenatal FISH With Reflex Cytogenetics, Amnio
6550	SNP Microarray POC	N/A	**Prenatal FISH With Reflex Cytogenetics, CVS
6100	Chorionic Villus Sampling: Full Chromosome Analysis	N/A	**Prenatal FISH With Reflex Cytogenetics, POC
1480	Fragile X Syndrome (Molecular Genetics)	LAB103530	ǂConstitutional FISH W/Reflex to Cytogenetics
2135	Noonan and Other Related Disorders Panel (Molecular Genetics)	1980	Maternal Cell Rule Out

* Chromosome studies will reflex to FISH if clinically relevant abnormalities are detected; appropriate charges will apply.

** Prenatal studies with microarray testing will need maternal blood collected in EDTA for MCRO testing.**

ǂConstitutional FISH W/Reflex to Cytogenetics requires 1 NaHep tube of blood and 1 EDTA tube of blood.

✦For all FISH With Reflex Cytogenetics orders, a FISH Assay must be selected, or the aneuploidy panel will be run as a default order.

FISH Assays

	Code	Test Name		Code	Test Name
	7018	Aneuploidy (chromosomes 13, 18, 21, X and Y)		8756	SHOX-related Haploinsufficiency Disorders, SHOX (Xp22.33)
	7020	Angelman Syndome / Prader Willi (SNRPN/ D15S63) (15q11-13)		7750	Smith-Magenis Syndrome
	8060	CEP X and CEP Y FISH		8762	SNRPN Dup(15) in autism
	8105	Cri-du-Chat (5p-) Syndrome (5p15.2)		8772	SRY-related disorders of sex development, SRY (Yp11.3)
	7140	DiGeorge Syndrome (TBX1)(22Q11.2)		8775	Steroid Sulfatase (STS) (Xp22.3)
	8395	Kallman Syndrome (KAL) (Xp22.3)		7870	Velocardiofacial Syndrome (TBX1)(22Q11.2)
	7510	Miller Dieker Syndrome, (LIS1)(17p13.3)		7900	Williams Syndrome (ELN) (7q11.23)
		Other (Clarify in Additional Comments Section)		7920	Wolf-Hirshhorn Syndrome, (WHS) (4p-) (WHSCR) (4p16.3)

Non-Testing Services

Code	Test Name	Code	Test Name
6240	Fibroblast Primary Culture	N/A	Primary Culture Sendout

Additional Comments

Result Release

Results will be immediately available to the patient unless you mark the box below.

Do not release (I reasonably believe that an Information Blocking exception applies)

Comments / Requests: