

POSTNATAL Test Request Form

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A. PATIENT IDENTIFICATION

NAME: _____ DOB: _____ MR#: _____ BIOLOGICAL SEX: Female
 Male
PHONE#: _____ ADDRESS: _____ CITY/ST/ZIP: _____

B. SPECIMEN INFORMATION

▪ Access specimen requirements at: www.reglab.org/services/human-genetics

▪ Ship specimens immediately - avoid extreme temperatures. Testing is most successful when performed on samples received within 24 hours of collection. If immediate shipment is not possible, contact us and store at room temperature.

NOTES:

COLLECTION DATE: _____ COLLECTION TIME: _____

SAMPLE TYPE: Blood Buccal mucosa* DNA Tissue / Skin

PATIENT CONSENT: Check this box if your patient does not wish to have their specimen stored. Consent is implied if box is left unchecked.

*FISH testing performed on a buccal specimen requires collection using a special kit that can be requested by calling client services.

C. TEST SELECTION

- Chromosome Analysis
- Chromosome Breakage for Fanconi anemia (SPPRB to Fairview)
- FISH - Aneuploidy [13, 18, 21, X, Y]
- FISH - Aneuploidy w/ reflex to chromosome analysis if abnormal
- FISH - 22q11.2 (FINT)
- FISH - Sex Determination [X, Y, SRY]
- FISH - [specify probe/region]: _____
Available probes: www.reglab.org/services/human-genetics/
- Fragile X (EDTA tube)
- Male Infertility PANEL [includes both tests listed below]
 - Chromosome Analysis ONLY
 - Y Chromosome Microdeletion (YCMD) ONLY
- Methylation Analysis - Chromosome 15 (SPPRB to ARUP)
[Prader-Willi syndrome, Angelman syndrome]
- Microarray Analysis - High Density SNP with confirmatory studies, if needed

OTHER TESTING

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

SPECIAL INSTRUCTIONS:

D. CLINICAL INFORMATION

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

ANCESTRY / FAMILY HISTORY:

- African American Ashkenazi Jewish
- Asian Central/Eastern European
- Latin American/Caribbean Middle Eastern
- Native American Western/Northern
- European
- Other:

CLINICAL INFORMATION:

INDICATIONS FOR TESTING:

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E. BILLING

☐ CLIENT BILLING

» Existing clients, please provide information below to be invoiced.
» To set up a new client billed account call 402-559-6420 and ask for an account manager.

FACILITY: _____

BILLING CONTACT: _____

PHONE: _____

PO#: _____

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

» Include an enlarged copy of both sides of the insurance card; Call 402-559-9480 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)

ICD CODE(S):

Patient insurance » If policy holder is different from patient, provide: _____ NAME _____ DOB _____
 Self-pay (patient billed after testing is completed)
 Pre-pay (testing begins once full payment is made) » RESPONSIBLE PARTY NAME: _____
ADDRESS: _____ PHONE#: _____ EMAIL: _____
CREDIT CARD#: _____ EXP DATE: _____ CVV: _____

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:** _____

F. RESULT REPORTING

▪ To establish/update your provider ordering profile, please contact your account manager

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 _____ **date** _____
(signed clinic notes will be accepted in lieu of a provider signature)

ORDERING LOCATION:

Facility: _____
Client Code: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____
Email: _____

ORDERING PROVIDER:

Name: _____
Delivery Method: _____

ADDITIONAL REPORT(S) TO:

Name: _____ Name: _____
Delivery Method: _____ Delivery Method: _____

G. SHIPPING

Shipping supplies including collection kits, tubes, transport media, and prepaid airbills are available through our supply portal.

Local Transport: Call the laboratory (402-559-6420) to request specimen pickup or utilize your routine RPS courier.

Shipping Address: UNMC Shipping & Receiving Dock
Regional Pathology Services MSB 3500
University of Nebraska Medical Center
601 Saddle Creek Road
Omaha, NE 68108-1180