



(PLEASE PRINT USING CAPITALS- FIELDS IN RED ARE REQUIRED)

(1) Patient Last Name <span style="float:right">First Name</span> <span style="float:right">Middle Name</span>			<div style="border: 1px solid black; height: 100%;"></div>	
(2) Name Change- Former Last Name				
(3) Patient Address				
(4) City	State	Zip		County of Residence
(5) Date of Birth	(6) Age	(7) Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
(8) Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latin	(9) <input type="checkbox"/> Amer Indian <input type="checkbox"/> Asian <input type="checkbox"/> Other _____	<input type="checkbox"/> Black/African Amer <input type="checkbox"/> Pacific Islander		<input type="checkbox"/> White
(10) Chart #/ Patient ID Number	(11) Submitter Specimen ID Number			(13) ADDITIONAL REPORT COPIES NEEDED?  Please check this box <input type="checkbox"/> AND Enter the clinician's name and address on the back of this form
(16) Attached copies of front and back of insurance card(s)? <input type="checkbox"/>				(14) Ordering Provider
(18) <input type="checkbox"/> MEDICAID# _____ <input type="checkbox"/> PRIVATE INSURANCE# _____				(15) NPI # _____
<input type="checkbox"/> MEDICARE# _____ <input type="checkbox"/> Bill to Submitter				
(20) Please write the letter corresponding to the appropriate ICD-10 Code to the left of the test name below (where applicable)				
(A) ICD-10 Code _____	(B) ICD-10 Code _____	(C) ICD-10 Code _____		(D) ICD-10 Code _____ (E) ICD-10 Code _____
(21) Date of collection	(22) Time of collection			
Specimen Source <input type="checkbox"/> Amniotic Fluid <input type="checkbox"/> Blood <input type="checkbox"/> Chorionic Villus Sample <input type="checkbox"/> Paraffin Section (tissue type _____)			Gestational Age: _____	
<input type="checkbox"/> Products of Conception (tissue type _____) <input type="checkbox"/> Tissue Biopsy (tissue type _____)			Ultrasound Age: _____	
			Estimated Date of Delivery: ___ / ___ / ___	
Reason for Referral (please provide in addition to ICD-10 code above):   				
Check all that apply:				
<b>CHROMOSOME ANALYSIS</b> <input type="checkbox"/> 801 Chromosome Analysis, Blood <input type="checkbox"/> 803 Chromosome Analysis, Blood, Abridged Examination for Familial Chromosome Rearrangements <input type="checkbox"/> 850 Chromosome Analysis, Amniotic Fluid <input type="checkbox"/> 852 Chromosome Analysis, Amniotic Fluid, Abridged (must also order 890PREC or 890PRET) <input type="checkbox"/> 855 Chromosome Analysis, Chorionic Villus Sample <input type="checkbox"/> 857 Chromosome Analysis, CVS, Abridged (must also order 890PREC or 890PRET) <input type="checkbox"/> 831 Chromosome Analysis, Products of Conception/ Tissue Biopsy <input type="checkbox"/> 860 Tissue culture and shipment for additional testing			<b>MOLECULAR ANALYSIS</b> <input type="checkbox"/> 828 Molecular Analysis, Fragile-X, Genetic Diagnosis <input type="checkbox"/> 889 Methylation-Specific PCR, SNRPN gene, 15q11.2 <input type="checkbox"/> 890 Array Comparative Genomic Hybridization, Microarray, aCGH <input type="checkbox"/> 890PREC Prenatal Microarray, Comprehensive <input type="checkbox"/> Tiered (Hold array pending chromosome analysis) <input type="checkbox"/> Concurrent (must also order 852 or 857) <input type="checkbox"/> 890PRET Prenatal Microarray, Targeted <input type="checkbox"/> Tiered (Hold array pending chromosome analysis) <input type="checkbox"/> Concurrent (must also order 852 or 857) <input type="checkbox"/> 895M40 Exome Sequencing Analysis with Mitochondrial Analysis <input type="checkbox"/> 895M50 Targeted Variant Analysis via Sanger DNA Sequencing  (variant nomenclature: _____) <input type="checkbox"/> 842C91 Hereditary Hemochromatosis [HHPCR] <input type="checkbox"/> 842C92 Factor II Genotyping [PTPCR] <input type="checkbox"/> 842C90 Factor V Genotyping [FVPCR]	<b>FISH ANALYSIS</b> <input type="checkbox"/> 873 Prenatal Aneuploidy Panel, Amniotic Fluid <input type="checkbox"/> 875 Stillbirth Aneuploidy Panel, Paraffin Embedded <input type="checkbox"/> 871F25 Angelman Syndrome, Deletion 15q11.2, D15S10/ UBE3A <input type="checkbox"/> 871F26 Cri du Chat (Cat Cry) Syndrome, Deletion 5p15.2, D5S721/D5S23 <input type="checkbox"/> 871F27 Deletion 1p36 Syndrome <input type="checkbox"/> 871F28 DiGeorge /Velo-cardio-facial /Schpritzen / Conotruncal anomaly Syndrome, Deletion 22q11.2, TUPLE1 <input type="checkbox"/> 871F30 Prader-Willi Syndrome, Deletion 15q11.2, SNRPN <input type="checkbox"/> 871F33 Wolf-Hirschhorn Syndrome, Deletion 4p16.3, WHS <input type="checkbox"/> 871F34 SRY (Sex determining Region of Y), Yp11.3 <input type="checkbox"/> 870F52X and Y sex chromosomes  <b>A sample processing fee is charged for blood samples that have only FISH analysis</b>
WSLH contributes submitted clinical information and test results for molecular cytogenetic tests to a HIPAA-compliant, de-identified public database a part of the National Institutes of Health's effort to improve diagnostic testing and our understanding of the relationships between genetic changes and clinical symptoms. For information about the ClinVar database, visit their website at <a href="http://www.ncbi.nlm.nih.gov/clinvar/">http://www.ncbi.nlm.nih.gov/clinvar/</a> . Confidentiality of each sample is maintained. Patients may request to withdraw consent for the storage of their sample and/or use of the data by: 1) checking the box below, 2) calling the laboratory at (608) 262-0402 and asking to speak with a genetic counselor, or by 3) visiting our website at <a href="http://www.slh.wisc.edu/cytogenetics">www.slh.wisc.edu/cytogenetics</a> .				
<input type="checkbox"/> Refusal for inclusion in these efforts may be indicated by checking this box. (If the box is not checked, the data will be anonymized and used.)				