Integrated GENETICS
LabCorp Specialty Testing Group

PRINT RESET

MOLECULAR GENETICS TEST REQUISITION

Highlighted fields are required.

Patient Information

Name
Last First MI

☐ Male ☐ Female Date of Birth / /

Address

Home Phone Work Phone

Social Security Number

City State Zip

Lab # Hospital #

Client Information

Client #: 602118 611956
University of Iowa Hospitals and Clinics
Department of Pathology
Commercial Mailouts - 6240 RCP
200 Hawkins Drive
Iowa City, IA. 52242-1009

Laboratory contact: Pam Roberts @ 319-356-8593

Please fax results report to 319-353-6130.

I attest that this patient has been informed about and has given consent for the test(s) I have ordered below under applicable law.

Physician/Authorized signature:

Referring Physician (print):

Genetic Counselor (print):

NPI#: Taxonomy#:

Laboratory Tests Ordered

Ashkenazi Jewish Testing (may be appropriate for other ethnicities)

☐ Check here for all Ashkenazi Jewish Tests or check separately

562 ☐ Bloom syndrome*
554 ☐ Canavan disease*
530 ☐ CF*plus*® (97 mutation test)*†
519 ☐ Dihydrolipoamide dehydrogenase deficiency*
207 ☐ Familial dysautonomia*
585 ☐ Familial hyperinsulinism*
534 ☐ Fanconi anemia (Group C)*
595 ☐ Gaucher disease*
522 ☐ Glycogen storage disease type 1a*
518 ☐ Maple syrup urine disease*
573 ☐ Mucolipidosis type IV*
587 ☐ Nemaline myopathy*
557 ☐ Niemann-Pick (type A)*
350 ☐ Tay-Sachs enzymes only
593 ☐ Tay-Sachs enzymes and DNA*
589 ☐ Usher syndrome type IF*
599 ☐ Usher syndrome type III*

Pan Ethnic Testing

☐ Check here for all Pan Ethnic Tests or check separately

530 ☐ CF*plus*® (97 mutation test)*†
523 ☐ Fragile X Carrier Screen (no family history, PCR only)†
516 ☐ Spinal muscular atrophy (SMA) Both parents bloods required for prenatal dx.*

Other Tests

565 ☐ Angelman syndrome – methylation
521 ☐ Fragile X Test (symptomatic/family history, PCR & Southern blot)*
582 ☐ Full cystic fibrosis gene sequencing *(Call laboratory before sending.)*
528 ☐ Maternal cell contamination (MCC) analysis*
583/584 ☐ Partial cystic fibrosis gene sequencing *(Call laboratory before sending.)*
565 ☐ Prader-Willi syndrome – methylation
574 ☐ Rhc/E analysis (also send parental bloods)*
575 ☐ RhD analysis (also send parental bloods)*
538 ☐ Poly (T) testing for CFTR Intron 8
535 ☐ Sickle cell anemia* (prenatal dx only)
591 ☐ Y chromosome microdeletion analysis
592 ☐ Zygosity

Thrombophilia

548 ☐ Factor V (Leiden)
549 ☐ Factor II (prothrombin G20210A)
526 ☐ MTHFR (C677T)

☐ Other _____

* Call before sending if for Fetal DNA. Maternal cell contamination analysis required for all prenatal dx (send a maternal sample).

† Reflex policy: The following will be performed by reflex at additional charge: **CFTR Intron 8 poly(T)** when R117H CF mutation is present; **Southern blot analysis** when Fragile X PCR shows >54 CGG repeats.

Date drawn: / /

Pregnancy: ☐ Yes ☐ No Gravida:_____ Para:_____(gravida 1 V22.0, gravida 2+ V22.1)
gestation _____ weeks

Specimen Type (Check one):

Parental ☐ Peripheral Blood ☐ Mouthwash ☐ Guthrie Card
Fetal ☐ Fetal Blood ☐ Amniotic Fluid ☐ Chorionic Villi ☐ POC
Back-up culture by: ☐ Integrated Genetics ☐ Other _____ Hold for:_____

Ethnicities (Check all that apply):

☐ Caucasian ☐ Ashkenazi Jewish ☐ Sephardic Jewish ☐ Asian ☐ African American
☐ Native American ☐ Hispanic ☐ Other: _____

Indication(s) for Test (check all that apply)

Diagnostic:
☐ Known affected_____
☐ Suspected: symptoms _____
☐ Congenital absence of vas deferens (752.89)
☐ Azoospermia (606.0) ☐ Oligospermia (606.1)
☐ Infertility (M:606.9, F: 628.9)
☐ Thrombophilia (286.9): specify _____

Carrier:
☐ No family history (screening) (V82.89)
☐ Family history (V18.9): relative _____
☐ Abnormal fetal ultrasound (655.83): specify _____
☐ Egg donor (V59.70) ☐ Sperm donor (V59.8)
☐ Known carrier (655.23): specify _____

Fetal:
☐ Family history (655.23): specify _____
☐ Abnormal fetal ultrasound (655.83): specify _____

Any Other Indication: provide ICD-9-CM code and description: _____
_____

BILLING INFORMATION

☐ BC/BS ☐ HMO ☐ PPO ☐ Indemnity ☐ Network ☐ Medicaid
☐ Medicare ☐ Medical Group/IPA ■ Client Bill ☐ CA XAFP ☐ Self-Pay
☐ Billing Information Attached (Please include a copy of insurance card or face sheet.)*
*Do not attach credit card information to this form for security purposes.

Insurance Company Name _____
Policy # _____ Group # _____
Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Patient Signature _____

INTEGRATED GENETICS INTERNAL USE ONLY

All Patients: I hereby authorize Esoterix Genetic Laboratories, LLC to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to Esoterix Genetic Laboratories, LLC. I understand that I am responsible for any amounts not paid by insurance for reasons including, but not limited to, noncovered and nonauthorized services. I permit a copy of this authorization to be used in place of the original.