2016 PRENATAL DIAGNOSIS REFERRAL FORM FOR CHROMOSOME ANALYSIS

Medical Genetics – Wake Forest University School of Medicine – Winston Salem NC
www.wfubmc.edu/medicalgenetics **Phone: 336-716-4321 Fax: 336-716-2554**

Collection Date: _____ **Time**: _____ am/pm **WFU LAB #:** _____

Name: _____/_____/_____/_____
(Please print) **Last** **First** **Middle** **Maiden**

Address: _____/_____/_____/_____**Daytime Phone:(____)_____**
Mailing Address **City** **State** **Zip**

Birth Date: _____ **SS# :** _____ **Patient's Mother's first name:**_____

Hospital : _____ **Hospital/Unit #:** _____ **Race:** _____

Type of Specimen: ☐ **Amniotic Fluid** ☐**CVS** ☐ **PUBS** ☐ **Tissue** ☐ **Blood** ☐ **Other:**_____

COLLECTION TECHNIQUE: **AF-** Discard the first 2 cc of fluid. Draw 20 -30 ml of fluid. **CVS**: >20mg tissue.
PUBS:1-2 mls in a green stoppered sodium heparin vacutainer. **KEEP ALL SAMPLES AT ROOM TEMPERATURE**

Physician/Provider Order

Physician: Last, First / Phone/beeper

1 | |

X

X Physician Signature Required

2. | |

Tap by:

Statement of Financial Responsibility

I authorize any holder of medical or other information about me to release to my healthcare provider, third party processor, the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this health care encounter or related claim. I permit a copy of this authorization to be used in place of the original, and request payment of authorized insurance benefits be made on my behalf to the WFU Physicians. I understand I am responsible for payment of these charges. I am also responsible for payment if my insurance carrier decides this is a non-covered service or requires prior authorization, which I did not obtain.

Patient Signature: _____ **Date:** _____

Billing Information

Bill: ☐ Forsyth Novant ☐ Moses Cone Hospital ☐ CFMFC
☐ Women's Hospt of Greensboro ☐ Wesley Long Hospital ☐ Other : _____
☐ Medicare # _____ ☐ Medicaid #: _____ ☐ Carolina Access# _____
☐ Insurance: _____ Employer: _____ Policy #:_____
(Enclose copy of both sides of insurance card)

OBSTETRIC / PATIENT INFORMATION

G_____ **P**_____ **A** _____ [SAB _____ TAB_____] **Gestation (wks):** LMP _____ or U/S_____

Genetic Counselor:_____ ***Does patient want to know sex of the fetus? :*** ☐ Yes / ☐ No

SIGNS/SYMPTOMS/INDICATION (ICD-10 CODES) FOR CHROMOSOME STUDY

Indicate **all** that apply. **Codes here do not represent entire listing of ICD-10 codes available**.
Please consult current ICD-10 codebook for complete listing.

☐ Advanced Maternal Age _____
☐ Suspected Fetal chromosome abnormality _____
☐ Abnormal Cell Free DNA _____
☐ Abnormal findings in amniotic fluid NOS
☐ Habitual aborter w/o current pregnancy
☐ Pregnancy with history of abortion
☐ Inc. Down Syndrome Risk → ☐ by Cell Free DNA / ☐ by Quad screen →→ → *{ } by WFUSM { } by outside lab*
☐ Inc. Trisomy 18 Risk → → ☐ by Cell Free DNA / ☐ by Quad screen → → → *{ } by WFUSM { } by outside lab*
☐ Neural Tube Defect Risk {Elev. MSAFP} →→ →*{ } by WFUSM { } by outside lab*
☐ Fetal abnormality by U/S - **specify**: _____
☐ Family history of genetic/chromosome disorder - **specify**:_____
☐ **Other Clinical/ICD-10 code specify**:_____

Test Requested **Note:** When ordering tests for which **Medicare** reimbursement will be sought, it is recommended that the Provider consult any Local Medical Review Policies (**LMRP**) or National Coverage Decisions (**NCD**) that may be applicable to the test(s) being ordered. Based on guidance issued in either of these policies it may be necessary to obtain an Advanced Beneficiary Notice (**ABN**) from the Medicare Patient. For Medicaid and other carriers a signed **Statement of Financial Responsibility** from the patient may be necessary. (See Statement of Financial Responsibility at top of form.)

TEST(s) REQUESTED

☐ **Routine chromosome / karyotype + AF-AFP + ACHe**
(88235, 88269 , 88280, 88285;82105;82013)
☐ **add Microarry**
☐ **Routine chromosome / karyotype + AneuVysion FISH (*13/18/21/X/Y*)**
(88235 , 88269 ,88280 ,88285, 88271x5, 88274 ;82105;82013) **+ AF-AFP + ACHe**
☐ **Routine chromosome / karyotype + specific FISH → → → →**
☐ **Culture and freeze cells** **+ AF-AFP + ACHe**

FISH Specific Probes

☐ Prader-Willi 15q12 ☐ Sex - X&Y
☐ DiGeorge/VCF 22q11 ☐ SRY Yp
☐ STS Xp22.3 ☐ KAL Xp
☐ Angelman 15q11
☐ Miller Dieker 17p13 ☐ other_____

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☐ **AF-AFP** ☐ **ACHe** ☐ **DNA** testing:_____

☐ **Culture & Hold cells per physician** ☐ **PCR Testing for:infec /micro/viral/etc**_____

CYTOGENETIC LAB USE ONLY

Name: _____ Lab #:_____
last first middle maiden

Date Received:_____/_____/_____ **Time Received**: _____

Sample Type: [ ] Amniotic Fluid [ ] CVS [ ] PUBS

Fluid appearance: [ ] clear [ ] cloudy [ ] bloody [ ] brown [ ] green [ ] clotted

Amount of fluid: _____ mls ***Size of pellet:*** [ ] tiny [ ] small [ ] medium [ ] large

Number of Tubes: [ ] 1 [ ] 2 [ ] 3 [ ] 4

Additional Specimen Evaluation:_____

_____

Primary Cultures: A B C D

Date culture initiated: _____/_____/_____ Tech: _____

Media: [ ] Amnio Max [ ] other:_____

SENT OUT: [ ] to referring institution / # flasks sent:_____ [ ] flasks frozen down / # flasks sent:_____

REPORT OF RESULTS / SPECIMEN SUMMARY

[ ] Final [ ] Preliminary [ ] Read Back Date_____Tech_____

To:_____

KARYOTYPE: [ ] 46,XY [ ] 46,XX Sex: [ ] Yes or [ ] No

INTERPRETATION: [ ] normal male [ ] normal female

[ ] abnormal:_____

[ ] AF on GEL

Additional Studies / Results: [ ] NOR [ ] C-band [ ] R-band

_____

FISH: [ ] normal male [ ] normal female
[ ] abnormal [ ] +13 [ ] +18 [ ]+21 [ ]+/-X/Y [ ] Other:_____

To:_____By:_____ Date_____