

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

FORM# 0000-9000

GCL CYTOGENETICS - GREEN

**PATIENT INFORMATION (YELLOW AREAS MUST BE FILLED IN)**

PATIENT LAST NAME			FIRST NAME			MI	PATIENT ID			DATE OF BIRTH			SEX M F		FASTING YES NO	
MAILING ADDRESS						ORDERING PHYSICIAN (FULL NAME)			COMMENTS OR ADDITIONAL COPY OF REPORT TO:							
CITY		STATE		ZIP		PATIENT PHONE			DATE COLLECTED			TIME COLLECTED AM PM		COLLECTED BY		

**WHEN MEDICARE PAYMENT WILL BE SOUGHT, ONLY TESTS WHICH ARE MEDICALLY NECESSARY SHOULD BE ORDERED.**

<b>B I L L T O</b>	<input type="checkbox"/> PHYSICIAN/PROVIDER <input type="checkbox"/> PATIENT            RESPONSIBLE PARTY (ONLY IF PATIENT IS A MINOR)		
	<b>SEE ATTACHED COPY OF CARD</b>		
	<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID (NON SALUD)		<input type="checkbox"/> PHP <input type="checkbox"/> BCBS <input type="checkbox"/> SALUD (Indicate Plan) <input type="checkbox"/> OTHER _____
	MEMBER # ON INSURANCE CARD: _____		INSURANCE ADDRESS: _____
PLAN NAME: _____		MEMBER ID NUMBER: _____	
GROUP NUMBER: _____		EMPLOYER OF PRIMARY CARDHOLDER: _____	

**STAT** Specify STAT TESTS: \_\_\_\_\_ **Note:** Only critical values will be called

Diagnosis / Indications for Chromosome Testing: \_\_\_\_\_

Comments: \_\_\_\_\_

- Has a genetic consent form been signed by the patient?
- Have previous cytogenetics been done?

**TESTS REQUESTED**

Lab Use Only  GYTGEN

INDIVIDUAL TESTS	ICD-9	INDIVIDUAL TESTS	ICD-9
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**Amniotic Fluid**

**Gestational Age** \_\_\_\_\_

- Chromosome Analysis \_\_\_\_\_
- AFP (Alphafetoprotein) \_\_\_\_\_
- AchE (Acetylcholinesterase) \_\_\_\_\_
- Prenatal Aneuploid Test (P.A.T.) (FISH for 13, 18, 21, X and Y) \_\_\_\_\_

**Chorionic Villi**

- Chromosome Analysis \_\_\_\_\_

**Peripheral Blood (Sodium Heparin Tube)**

- Chromosome Analysis \_\_\_\_\_
- High Resolution Study \_\_\_\_\_

**POC - Products of Conception**

- Chromosome Analysis \_\_\_\_\_

**Other**

- \_\_\_\_\_

**Skin Biopsy**

- Chromosome Analysis, Solid Tissue \_\_\_\_\_
- Tissue Culture Only \_\_\_\_\_

**Oncology Testing**

- Chromosome Analysis, Blood  
WBC count: \_\_\_\_\_ %    Blasts: \_\_\_\_\_
- Chromosome Analysis, Bone marrow \_\_\_\_\_
- Chromosome Analysis, Solid Tumor \_\_\_\_\_  
Tumor type: \_\_\_\_\_

**Fluorescence in Situ Hybridization (FISH)**

- |  |  |
|--|--|
| <input type="checkbox"/> CLL                 | <input type="checkbox"/> t(15;17) AML          |
| <input type="checkbox"/> Myelodysplasia      | <input type="checkbox"/> DiGeorge              |
| <input type="checkbox"/> Myeloma             | <input type="checkbox"/> Smith-Magenis         |
| <input type="checkbox"/> Burkett t(8;14)     | <input type="checkbox"/> Prader-Willi          |
| <input type="checkbox"/> 11q23 (MILL gene)   | <input type="checkbox"/> Cri-du-Chat           |
| <input type="checkbox"/> X,Y                 | <input type="checkbox"/> Williams              |
| <input type="checkbox"/> BCR-ABL1 t(9;22)    | <input type="checkbox"/> Miller Dieker         |
| <input type="checkbox"/> t(11;14) Mantle     | <input type="checkbox"/> Trisomy: 13, 18 or 21 |
| <input type="checkbox"/> t(14;18) Follicular | <input type="checkbox"/> Other: specify _____  |
| <input type="checkbox"/> t(12;21) TEL/AML1   |  |
| <input type="checkbox"/> t(8;21) AML         |  |
| <input type="checkbox"/> inv16 AML           |  |

**ADDITIONAL REPORTS TO**

**SHIP TO ADDRESS**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State/Zip: \_\_\_\_\_  
 Fax: \_\_\_\_\_

TriCore Reference Laboratories  
 Att: Cytogenetics  
 1001 Woodward Place NE  
 Albuquerque, NM 87102  
**Phone:** (505) 938-8430  
**Fax:** (505) 938-8432

**Send Sample With Requisition  
 (DO NOT SEPARATE)**

**48 HR TEST DELAY**

**Informed Consent for Genetic Analysis**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ GENDER:  M  F

I request genetic analysis for the purpose of:

- Cytogenetic analysis for constitutional abnormalities       Hemochromatosis mutation detection       Other  
 Cystic Fibrosis

I request and authorize the physician identified below and/or TriCore Reference Laboratories to collect, obtain, retain, transmit, and use genetic information and samples for genetic analysis from (check one):

- me       my minor child       my fetus       \_\_\_\_\_

for the purpose listed above. My signature below constitutes my acknowledgement that the principles, benefits, and risks of genetic analysis have been explained to my satisfaction by the physician listed below or by a genetic counselor. I acknowledge that I have had the opportunity to ask questions concerning the genetic analysis that is to be performed and the use of the test results and that my questions have been answered to my satisfaction.

I understand the following about the test procedure and its outcome:

1. Genetic analysis may:
  - a) Diagnose whether I am or am not affected with this condition;
  - b) Predict whether I am or am not at risk for developing this condition;
  - c) Indicate whether I am or am not a carrier for this condition; or
  - d) Be indeterminate due to limitations of current technology.
2. This genetic analysis may be specific only for the condition named above. It will not detect all mutations possible within this gene nor detect mutations in other genes.
3. The significance of a positive and a negative test result based on my family history has been explained.
4. Although mutation and/or linkage analyses usually yield precise information, several sources of error are possible, including those due to inaccurate information regarding family relatedness.
5. Through genetic analysis, the laboratory may discover false paternity. A genetic analysis may also suggest a genetic condition in another family member.
6. Genetic analysis results may cause emotional stress. All test results are treated with standard medical confidentiality. If an insurance provider requires test results for reimbursement purposes, I authorize the laboratory to release them. New Mexico and several other states have laws prohibiting discrimination by health insurers on the basis of pre-symptomatic genetic testing results.
7. Genetic analysis may involve complex, multi-part processes. Turn-around times are only estimates and cannot be guaranteed. Occasionally, the laboratory may request a second sample for genetic analysis.
8. After genetic analysis is completed, any remaining sample material may be retained, transmitted and/or used for quality assurance or education purposes or for scientific or medical research under the oversight of an Institutional Review Board. Refusal to permit the use of my sample for research will not affect this test procedure. I can withdraw my consent at any time by contacting the director of the laboratory that performed this genetic testing. **If you do not consent to the use of your sample for research, please sign here.** \_\_\_\_\_

**PATIENT CONSENT: The content of this form has been explained to me by my healthcare provider and my signature indicates consent for the genetic test indicated above.**

Name of Referring Physician: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_