



## Cytogenetics Laboratory Test Request Form

**Please help to avoid delays! Provide complete and legible information & a full copy of the insurance card.**

*The medical necessity of all clinical laboratory tests must be substantiated by an appropriate clinical diagnosis.*

Patient Name (Last, First, MI) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_ Patient Social Security # \_\_\_\_\_

Patient Medical Record # \_\_\_\_\_ Parent's/Guarantor's Name \_\_\_\_\_ Signature \_\_\_\_\_

Patient Address (or insured/ responsible party) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co & Address \_\_\_\_\_ Ins Authorization # \_\_\_\_\_ Group # \_\_\_\_\_ Member # \_\_\_\_\_

Clinical Information & Diagnosis/ICD9 Codes \_\_\_\_\_

If Pregnant: G: \_\_\_\_\_ P: \_\_\_\_\_ TAB: \_\_\_\_\_ SAB: \_\_\_\_\_ LMP/US/Physical Exam on \_\_\_\_/\_\_\_\_/\_\_\_\_ Gestation Age: \_\_\_\_\_

*I authorize the release of any medical information necessary for my insurance carrier to process this claim. I understand I may be held responsible for any portion of the claim that the insurance company does not pay. This statement does not apply to Medicare or Medicaid recipients. I authorize payment directly to Childrens Hospital Los Angeles Laboratory.*

Physician's Name \_\_\_\_\_ License # \_\_\_\_\_ Phone/Pager # \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_ Physician's Signature & Date \_\_\_\_\_

**Specimen Drop Off :**

**Cytogenetics Laboratory: 4650 Sunset Blvd., M/S 32, 2nd floor Duque Bldg., RM 2-162 Los Angeles, CA 90027. Phone 323 361-7301 , Fax 323 361-1087**

**Specimen Type:**

<input type="checkbox"/> Amniotic fluid	<input type="checkbox"/> Bone Marrow (WBC: _____)	<input type="checkbox"/> Tumor Tissue
<input type="checkbox"/> Blood, Na Hep Green Top Tube	<input type="checkbox"/> Skin Biopsy	<input type="checkbox"/> CSF
		<input type="checkbox"/> Other: _____

**Cytogenetics**

<input type="checkbox"/> Chromosome, High Resolution
<input type="checkbox"/> Chromosome, Standard
<input type="checkbox"/> Chromosome, Breakage Study
<input type="checkbox"/> Chromosome, Mosaicism
<input type="checkbox"/> Cell Culture Only
<input type="checkbox"/> Other: _____

**FISH Studies:  
Aneuploidy & Microdeletion**

<input type="checkbox"/> Monosomy Syndrome (Specify: _____)
<input type="checkbox"/> Trisomy Syndrome (Specify: _____)
<input type="checkbox"/> Sex Chromosome (X and Y)
<input type="checkbox"/> Cri-du-Chat Syndrome (5p15.2)
<input type="checkbox"/> DiGeorge/VCF Syndrome (22q11.2)
<input type="checkbox"/> Kallmann Syndrome (Xp22.3)
<input type="checkbox"/> Miller-Dieker Syndrome (17p13.3)
<input type="checkbox"/> Prader-Willi/Angelman Syndrome (15q11-13)
<input type="checkbox"/> Retinoblastoma (13q14) [RB]
<input type="checkbox"/> Smith-Magenis Syndrome (17p11.2)
<input type="checkbox"/> Williams Syndrome (7q11.23)
<input type="checkbox"/> Wolf-Hirschhorn Syndrome (4p16.1)
<input type="checkbox"/> Subtelomere
<input type="checkbox"/> Other: _____

**FISH Studies:  
Oncology**

<input type="checkbox"/> ETO/AML1 Fusion Gene (AML)
<input type="checkbox"/> BCR/ABL Fusion Gene (CML, ALL, AML)
<input type="checkbox"/> IGH/MYC Fusion Gene (ALL, Lymphoma)
<input type="checkbox"/> PML/RARA Fusion Gene (APL)
<input type="checkbox"/> TEL/AML1 Fusion Gene (ALL)
<input type="checkbox"/> 1p/19q Deletion (Oligodendroglioma)
<input type="checkbox"/> 2p23 (ALK) Rearrangement (Ki-1 lymphoma)
<input type="checkbox"/> 11q23 (MLL) Rearrangement (AML, ALL)
<input type="checkbox"/> 16q22 (CBFB) Rearrangement (AML-M4)
<input type="checkbox"/> 22q12 (EWSR1) Rearrangement (Ewing sarcoma)
<input type="checkbox"/> New ALL Panel (TEL/AML, BCR/ABL, MLL, CEP 4, 10, 17)
<input type="checkbox"/> New AML Panel (EGR1/D5S23, D7S486/CEP7, ETO/AML1, MLL, CBFB)
<input type="checkbox"/> Other: _____

Source	Collected Date	Collected Time	Comment