Cytogenetics Request Form

Greenwood Genetic Center
106 Gregor Mendel Circle • Greenwood, SC 29646
Toll Free: (800) 473-9411 • Fax: (864) 941-8141
Website: www.ggc.org Highlighted boxes are required

LAB USE ONLY

Patient Information (Please Print):

Last Name First MI		Address	
Race/Ethnicity	Sex ☐ M ☐ F	DOB MM/DD/YYYY	City, State, Zip
Specimen Collection Date MM/DD/YYYY	Type of specimen*	Numeric Identifier (Medical record # or SSN)	Home telephone

*DNA samples only: Please identify where DNA extraction was performed.
☐ **CAP/CLIA Accredited Lab:** _____ ☐ **Research Lab:** _____ ☐ **Unknown**

Referring Physician:

Name	Address	
Institution	City, State, Zip	
NPI#	Telephone	Fax
Email Address:	Preferred Method to Receive Results: ☐ Secure Email ☐ Fax ☐ Regular Mail	

Additional report to: ☐ **Genetic Counselor** ☐ **Institution** ☐ **Care Coordinator** ☐ **Other:**

Name		Address	
Telephone	Fax	Email:	City, State, Zip

Additional report to: ☐ **Genetic Counselor** ☐ **Institution** ☐ **Care Coordinator** ☐ **Other:**

Name		Address	
Telephone	Fax	Email:	City, State, Zip

Billing: Select how the test(s) will be billed & complete the billing information on the next page. The BILLING FORM on page 2 is required.

☐ **Institutional Billing: Complete section 1 on the separate BILLING FORM (page 2)**

☐ **Insurance: Complete section 2 on the BILLING FORM (page 2). WE DO NOT ACCEPT INSURANCE OR MEDICAID FOR NON-SC PATIENTS.**

☐ **Self-pay: Complete section 3 on the separate BILLING FORM (page 2).**

Indication for Study & Clinical Information: Please attach pedigree

☐ ICD10 Code(s): _____

☐ Symptomatic, specific findings: _____

☐ Family History _____

Is the patient currently pregnant? ☐ No ☐ Yes If so, provide LMP: _____ or EDD: _____ Gestational Age: _____

Ultrasound findings_____

CHROMOSOME STUDIES ●*
- ☐ High Resolution Chromosomes
- ☐ High Resolution Chromosomes, Rule Out Mosaic
- ☐ Routine Blood Chromosomes
- ☐ Routine Blood Chromosomes, Rule Out Mosaic
- ☐ Routine Blood Chromosomes, Short Study

CHROMOSOME STUDIES (POC, Solid Tissue)*
- ☐ Solid Tissue Chromosomes
- ☐ Solid Tissue Chromosomes, Rule Out Mosaic
- ☐ Solid Tissue Chromosomes, Short Study

AMNIOTIC FLUID (AF) STUDIES *
- ☐ Chromosomes, Routine
- ☐ Chromosomes, Short Study
- ☐ Chromosomes, Rule Out Mosaic
  - ☐ AFP ☐ AChE (Sendouts)
- ☐ Trisomy Screen – FISH (13,18,21,X,Y)

CHORIONIC VILLUS SAMPLING (CVS) *
- ☐ Chromosomes, Routine
- ☐ Chromosomes, Short Study
- ☐ Trisomy Screen – FISH (13,18,21,X,Y)
- ☐ Maternal Cell Contamination **Required** (►/◄/Saliva)

MICROARRAY (►,◄, or Saliva except where indicated)*
- ☐ Cytogenomic Microarray **(Tissue also accepted)**
- ☐ Targeted Deletion/Duplication Analysis (qPCR)
  Please Specify Proband:
  _____
- ☐ Prenatal Microarray **(Amniotic Fluid or CVS)**
  Parent Samples Included:
  - ☐ Mom's Sample
  - ☐ Dad's Sample (separate requisition required)
- ☐ Pregnancy Loss (POC) Microarray **(POC, Tissue, ◄)**
  - ☐ Maternal Cell Contamination **Recommended**
- ☐ Targeted Infertility Microarray

FISH FOR CONGENITAL ANOMALIES (Buccal) ^
- ☐ Disorders of Sexual Development, Routine (includes SRY/Xcen & X/Y dual assay probes)
- ☐ Disorders of Sexual Development, Rule Out Mosaic (includes SRY/Xcen & X/Y dual assay probes)
- ☐ Trisomy Screen (13), Rule Out Mosaic
- ☐ Trisomy Screen (18), Rule Out Mosaic
- ☐ Trisomy Screen (21), Rule Out Mosaic

FISH FOR CONGENITAL ANOMALIES (Blood) ●*
(AF/CVS considered for all. Call lab before sending)
- ☐ Angelman Syndrome (15q11q13)
- ☐ DiGeorge/VCF Syndrome (22q11)
- ☐ Disorders of Sexual Development
- ☐ Disorders of Sexual Development, Rule Out Mosaic
- ☐ Prader-Willi Syndrome (15q11q13)
- ☐ Trisomy Screen (13,18,21,X,Y)

ONCOLOGY *
- ☐ Chromosomes (Bone Marrow)
- ☐ Chromosomes (Stimulated/Unstimulated Blood) ●

OPTICAL GENOME MAPPING (OGM) ►◆
- ☐ OGM Complete
- ☐ OGM Targeted
  Specify Gene(s) or Region: _____
- ☐ OGM – FSHD1

OTHER
- ☐ DNA Banking
- ☐ Cell Culture Only
- ☐ Other: _____

► **Requires purple-top/EDTA tube** ● **Requires green-top/sodium heparin tube** ***Room temperature/Next-day delivery** ^**Buccal (GGC Kit Required)** ◄**Extracted DNA**
◆**Next-day delivery. If blood is fresh (preferred), send with cold pack (≥4°C). If blood is frozen, send on dry ice.**
Please call 800-473-9411 to check for the availability of additional Cytogenetic testing options including the ability to perform prenatal testing where it is not listed.

LAB USE ONLY Accessioned By: Event Codes: FedEx Eagle UPS DHL WC USPS Other:

EDTA	Na Hep	Plasma / Serum	Urine	Flasks / Tissue	DBS / DNA	Saliva / Swab Buccal	PAX	ACD
RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F

Greenwood Genetic Center

Diagnostic Laboratory Billing Form

This page is required to process any test requests.

LAB USE ONLY

- **No out of state (non-SC) insurance will be accepted for any tests.**
- **The following items are needed in order to bill the patient's insurance directly. We will not be able to file the claim if we are missing information.**
  - ☐ **This form must be completed with ALL requested information.**
  - ☐ **A legible copy of both sides of the insurance card**
  - ☐ **Authorization number, authorization letter, or letter of agreement from insurance company**

Patient Information:

Last Name First MI		Address	
Numeric Identifier (Medical record # or SSN)	DOB MM/DD/YYYY	City, State, Zip	Telephone
ICD10 Code(s)			

Section 1: Institutional Billing

Complete section below with institution information. *New clients must complete an INSTITUTIONAL ACCOUNT REQUEST FORM when submitting the order.* Please contact the GGC Billing Office at 864-941-8117 or billing@ggc.org with any questions about your account.

Institution/Organization	Contact Name:	Email:
Billing Address	City, State, Zip	
Account Number:	Telephone	Fax

Section 2: Insurance Information INSURANCE OR MEDICAID FOR OUT-OF-STATE (NON-SC) PATIENTS IS NOT ACCEPTED

MUST INCLUDE LEGIBLE COPY OF INSURANCE CARD (FRONT & BACK)
All information required to file insurance claims.

Primary

Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender ☐ Male ☐ Female
Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
Authorization Number (attach copy of authorization letter) *Required	Insurance City, State, Zip	Phone

Secondary

Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender ☐ Male ☐ Female
Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
Authorization Number (attach copy of authorization letter) *Required	Insurance City, State, Zip	Phone

I authorize Greenwood Genetic Center (GGC) Diagnostic Laboratories to furnish any medical information requested of me, or my covered dependents. In consideration of services rendered, I transfer and assign any benefits of insurance to GGC Diagnostic Laboratories. I understand I am responsible for any co-pay, deductibles, non-authorized, or non-covered services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if the GGC Diagnostic Laboratories is not a participant with my health plan, or my health plan does not fully reimburse my medical services due to lack of authorization for medical necessity.

Printed Name: _____ Signature: _____ Date (MM/DD/YY): _____

Section 3: Self-pay

We accept check/Visa/MasterCard/American Express/Discover. All information required to process credit card payments.
Payments will be processed prior to initiation of testing.

Payment Method: ☐ Check ☐ Visa ☐ MasterCard ☐ AmEx ☐ Discover	Credit Card Number:	
Amount: (with discount applied if applicable)	Exp. Date	CVV
Cardholder Name(print as it appears on the card):	Cardholder Signature:	Date
Billing address	City, State, Zip	Telephone