UNIVERSITY of VIRGINIA HEALTH SYSTEM

CYTOGENETICS LAB TEST REQUEST FORM

(434) 924-2415

CHECK APPROPRIATE BOX FOR BILLING

☐ INSURANCE BILLING: COMPLETE SECTION 1-5 BELOW

☐ PATIENT BILLING (SELF PAY): COMPLETE SECTION 1-2 BELOW

☐ INPATIENT

☐ GRANT ACCOUNT _____

☐ WHOLESALE/ACCOUNT _____

3000001

PATIENT NAME (LAST, FIRST, MI) - PLEASE PRINT	LAST	FIRST	MIDDLE	SEX ☐ M ☐ F
PATIENT HISTORY #	DOB	PHYSICIAN NAME (LAST, FIRST)	PHONE/PIC #	
PHYSICIAN SIGNATURE				
PATIENT LOCATION	DATE & TIME OF COLLECTION			

Date Received _____ Time _____

1. PATIENT ADDRESS (STREET OR PO BOX)	CITY/STATE	ZIP CODE	
2. PATIENT PHONE #	PATIENT SOCIAL SECURITY #	PATIENT MARITAL STATUS ☐ S ☐ M ☐ W ☐ D	RACE ☐W ☐B ☐OTHER
GUARANTOR NAME (LEAVE BLANK IF PATIENT IS GUARANTOR)	GUARANTOR PHONE #	RELATIONSHIP TO PATIENT	
GUARANTOR ADDRESS (STREET OR PO BOX)	CITY/STATE	ZIP CODE	
3. MEDICARE: PRIMARY/SECONDARY	MEDICARE # & LETTER	4. MEDICAID #	STATE	EFFECTIVE DATE
5. OTHER INSURER ☐ PRIMARY ☐ SECONDARY	COMPANY NAME	ADDRESS	PHONE #	
EFFECTIVE DATE	SUBSCRIBER NAME	POLICY #	GROUP #	

CHECK APPROPRIATE BOXES FOR TEST ORDER:

Specimen Type

☐ Amniotic Fluid
☐ Blood
☐ Bone Marrow
☐ Blood for Leukemic Studies
☐ Chorionic Villi Sampling
☐ Fetal/Stillborn Tissue
☐ Other Fibroblast
☐ Skin

Study Type: (Check as many as appropriate)

☐ Karyotype*
☐ Breakage: ☐ DEB ☐ Mito C
☐ FISH Specify _____
☐ Sister Chromatid Exchange
☐ Cell Line Build Up
☐ Confirmation Study
☐ Other _____

CLINICAL INFORMATION: (Must be completed)

ICD-9 _____

_____

_____

_____

_____

FOR OB PATIENTS

G _____ P _____ A _____ LMP _____ Gestational Age _____

Requesting Physician _____ PIC # _____
must sign

Copy To _____

Note: *Denotes a test that may result in an automatic reflex to FISH analysis unless otherwise indicated

4/05