2011 CHROMOSOME ANALYSIS FOR TISSUE 2010
STILLBIRTHS, MISCARRIAGES AND FETAL DEMISE

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 Name and Unit # : _____ ***Presumed Sex of Fetus***:☐ male☐ female ☐ could not be determined

Type of Specimen: ☐ POC ☐ cord ☐ skin ☐ lung ☐ fascia ☐ amniotic fluid ☐ CVS ☐ blood ☐ placenta

COLLECTION TECHNIQUE: **Tissue sample**: place sterilely into media or alternatively in sterile buffer.
AF- Place in a sterile container. **CVS***:* Place in a sterile container. **Blood***:*1-2 mls in a green stoppered sodium heparin vacutainer.
KEEP ALL SAMPLES AT ROOM TEMPERATURE / REFRIGERATE OVER NIGHT

Physician/Provider Order

Physician: Last, First / Phone/beeper

1.
X.
X. Physician Signature Required
2.
3.

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 ☐ Moses Cone/Spectrum
☐ Spectrum ☐ 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): _____

SIGNS/SYMPTOMS/INDICATION (ICD-9 CODES) FOR CHROMOSOME STUDY

Indicate all that apply. **Codes here do not represent entire listing of ICD-9 codes available**. Please consult current ICD-9 code book for complete listing.

☐ Fetal demise intrauterine death, unspecf *(656.40)*
☐ Unspecified Neonatal Death *(674.94)*
☐ Spontaneous abortion – no complication *(634.90)*
☐ Stillbirth NEC *(779.9)*
☐ Other abnormal product of conception *(631)*
☐ Hydatidiform mole *(630)*
☐ Fetal Growth Retardation, NOS *(764.90)*
☐ Congenital anomaly NOS *(759.9)*
☐ Indeterminate sex *(752.7)*
☐ Hydrocephalus *(653.63)*
☐ Inc. bil.Cleft lip/palate *(749.24)*
☐ Cystic hygroma *(228.1)*
☐ Abdominal wall defect omphalocele *(756.79)*
☐ Holoprosencephaly *(742.2)*
☐ Abnormal skull/facies *(756.0)*
☐ Cong heart anom other *(746.89)*
☐ Abnormal U/S specify:_____
☐ Abnormal ears *(744.29)*
☐ Renal disorder (_____)
☐ Eye abnormality NOS *(743.9)*
☐ Limb defect specify: (_____)
☐ *Amnio/CVS confirmation*
☐ *Blood/amnio mosaicism*
☐ **Other ICD-9 / Clinical 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**
(88233,88262, 88280, 88285)
☐ **Routine chromosome / karyotype +FISH** ***select one*** → →
(88233, 88262, 88280, 88285, 88271 x 6, 88274 x 6)
☐ **Culture** / ☐ **Send out** / ☐ **Freeze**

FISH Specific Probes

☐ Aneuploidy screen: 13, 16, 18, 21, X, Y
☐ +13 ☐ +18 ☐ +21 ☐ X ☐ Y
☐ Prader-Willi 15q12
☐ DiGeorge/VCF 22q11
☐ Angelman 15q12
☐ Sex - X&Y
☐ SRY Xp
☐ STS Xp22.3

☐ **DNA** testing:_____ ☐ **Hold cells per physician** ☐ **Culture and freeze cells**

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

CYTOGENETIC LAB USE ONLY

Name: _____Lab #:_____
last first middle maiden

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

Sample Type: ☐ POC ☐ cord ☐ skin ☐ lung ☐ fascia
☐ amniotic fluid ☐ CVS ☐ blood ☐ placenta

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

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

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

Additional Specimen Evaluation:_____

_____

Primary Cultures: A B C D
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:_____

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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:_____

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

_____

[ ] AF on GEL

FISH: [ ] normal male [ ] normal female

[ ] abnormal [ ] +13 [ ] +18 [ ]+21 [ ]+/-X/Y [ ]other:_____

To:_____By:_____ Date_____