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 ☐ Sex - X&Y
☐ DiGeorge/VCF 22q11 ☐ SRY Xp
☐ Angelman 15q12 ☐ STS Xp22.3

☐ **DNA testing**:__________ _ _______________ ☐ **Hold cells per physician** ☐ **Culture and freeze cells**

CHROMOSOME ANALYSIS FOR TISSUE

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 #:** __________________

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:______
==

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______________