2006 PERIPHERAL BLOOD REFERRAL FORM FOR CHROMOSOME ANALYSIS

Medical Genetics – Wake Forest University School of Medicine – Winston Salem NC
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# :** _____ **Sex:** ☐ male / ☐ female

Hospital : _____ **Hospital/Unit #:** _____ **Patient's Mother's first name:**_____

Type of Specimen: ☐ **Blood** ☐ **PUBS** ☐ **Blood (POC)** ☐ **Caner**

Collection Technique: 5 – 10 mls blood collected in a green stoppered sodium heparin tube. **Keep at room temperature**

Physician Information	
Physicians: Last, First	Phone/beeper:
1	
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 Hospital ☐ Moses Cone Hospital
☐ 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)

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.

☐ Other chromosome conditions (758.9)
☐ Other sex chromosome anomaly (758.81)
☐ Ambiguous genitalia (752.9)
☐ Multiple congenital anomalies (759.7)
☐ Unspec anom congen anomaly (759.9)
☐ Other Specified anomalies (759.89) congenital
☐ Developmental delay (315.9) NOS
☐ Delayed learning (315.2) NOS
☐ Anomalies face/neck (744.89)
☐ Eye anomaly (743.9) NOS
☐ Cleft lip/palate (749.20) NOS
☐ Hypotonia, cong. (779.89)
☐ Obesity (278.00)
☐ Delay in sexual development (259.0)
☐ Abnormal ears (744.29)
☐ Short Stature (783.43)
☐ Lack of nml physiological dev (783.40)
☐ Brain anomalies (742.4) NOS
☐ Failure to thrive (783.41)
☐ Mixed develop disorder (315.5) NOS
☐ Other spec cond. perinatal (779.89)
☐ Fam hx of other cong anomal (V19.5)
☐ Family hx, mental retardation (V18.4)
☐ Fam hx other other conditions (V19.8)
☐ MR Moderate (318) ☐ Severe (318.1) ☐ Profound (318.2)
☐ Infertility -> ☐ female (628.9) NOS / ☐ male (606.9) NOS)
☐ Congen heart anomaly (746.89)
☐ Language Delay (315.31)
☐ Multiple Miscarriages (habitual abortion) {G ____ P ____ A ____} [SAB ___ TAB ____]
☐ **Additional Clinical Information/ICD-9 codes:**_____

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.)

SUSPECTED DIAGNOSIS OR CHROMOSOME ABNORMALITY *(not for billing purposes)*

☐ Trisomy 21 (Down Syndrome)
☐ Trisomy 13
☐ Trisomy 18
☐ Turner Syndrome (45,X)
☐ Fragile X Syndrome
☐ Prenatal confirmation
☐ Prader Willi Synd. (15q-)
☐ Angelman Synd. (15q-)
☐ Smith Magenis Synd. (17p-)
☐ Di-George/ VCF Synd. (22q-)
☐ Miller-Dieker Synd. (17p-)
☐ Klinefelter Syn. (47,XXY)
☐ Specific Chromosome abnormality or syndrome: _____ ☐ Habitual Aborter
☐ Other genetic/chromosome abnormality: _____

TEST REQUESTED	FISH Specific Probes	
☐ **Routine Chromosome / karyotype** *(7 - 10 days)* *(88230, 88262, 88280, 88285)*	☐ Angelman **15q12**	☐ +13 ☐ +18 ☐+21
☐ **STAT Chromosomes** *(48 hrs. - additional charges)* *(88230 88262,88280, 88285, 88261)*	☐ Prader-Willi **15q12**	☐ Sex - X&Y
☐ **Chromosome / karyotype +Stat FISH (*13/18/21/X/Y*)** *(88230, 88262, 88280, 88285,88271x5, 88274x5)*	☐ DiGeorge/VCF **22q11**	☐ SRY **Yp22.3**
☐ **Routine Chromosome / karyotype +FISH** select → →	☐ Miller-Dieker **17p13**	☐ 4p-
☐ **FISH Only - chromosome previously done** select → → →	☐ STS **Xp22.3**	☐ 5p-
	☐ Kallmans **Xp22.3**	☐ _____
	☐ Smith-Magenis **17p11**	☐ M-FISH
	☐ Williams **7q22**	☐ Subtelomere

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