

2010 **PRENATAL DIAGNOSIS REFERRAL FORM FOR CHROMOSOME ANALYSIS**

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 :** \_\_\_\_\_ **Hospital/Unit #:** \_\_\_\_\_ **Race:** \_\_\_\_\_

**Type of Specimen:**  Amniotic Fluid  CVS  PUBS  Tissue  Blood  Other: \_\_\_\_\_

**COLLECTION TECHNIQUE:** AF- Discard the first 2 cc of fluid. Draw 20 -30 ml of fluid. CVS: >20mg tissue.  
 PUBS: 1-2 mls in a green stoppered sodium heparin vacutainer. **KEEP ALL SAMPLES AT ROOM TEMPERATURE**

Physician Information		Statement of Financial Responsibility
Physician: Last, First	Phone/beeper	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.
1		
2		
Amnio Tap by:		<b>Patient Signature:</b> _____ <b>Date:</b> _____

Billing Information	
<b>Bill:</b> <input type="checkbox"/> Forsyth Hospital <input type="checkbox"/> Moses Cone Hospital <input type="checkbox"/> CFMFC	<input type="checkbox"/> Spectrum <input type="checkbox"/> Women's Hospt of Greensboro <input type="checkbox"/> Wesley Long Hospital <input type="checkbox"/> Other : _____
<input type="checkbox"/> Medicare # _____	<input type="checkbox"/> Medicaid #: _____
<input type="checkbox"/> Carolina Access# _____	
<input type="checkbox"/> Insurance: _____	Employer: _____ Policy #: _____
(Enclose copy of both sides of insurance card)	

**OBSTETRIC / PATIENT INFORMATION**

**G** \_\_\_\_\_ **P** \_\_\_\_\_ **A** \_\_\_\_\_ [ **SAB** \_\_\_\_\_ **TAB** \_\_\_\_\_ ] **Gestation (wks):** LMP \_\_\_\_\_ or U/S \_\_\_\_\_

**Genetic Counselor:** \_\_\_\_\_ **Does patient want to know sex of the fetus? :**  Yes /  No

**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 codebook for complete listing.

- Advanced Maternal Age (659.63) \_\_\_\_\_
- Suspected Fetal chromosome abnormality (655.13)
- Fetal abnormality antepartum (655.93)
- Inc. Down Syndrome Risk {AFP/hCG/uE3} (796.5) → → → { } by WFUSM { } by outside lab: \_\_\_\_\_
- Inc. Trisomy 18 Risk {AFP/hCG/uE3} (796.5) → → → { } by WFUSM { } by outside lab: \_\_\_\_\_
- Neural Tube Defect Risk {Elev. MSAFP} (796.5) → → → { } by WFUSM { } by outside lab: \_\_\_\_\_
- Abnormal abdomen Ultrasound (793.6)- **specify:** \_\_\_\_\_
- Family history of genetic/chromosome disorder (V19.8) -**specify:** \_\_\_\_\_
- Other Clinical/ICD-9 code **specify:** \_\_\_\_\_
- Abnormal findings in amniotic fluid NOS (792.3)
- Habitual aborter w/o current pregnancy (629.9)
- Pregnancy with history of abortion (V23.2)

**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	FISH Specific Probes
<input type="checkbox"/> Routine chromosome / karyotype (88235, 88269, 88280, 88285)	<input type="checkbox"/> Prader-Willi 15q12 <input type="checkbox"/> Sex - X&Y
<input type="checkbox"/> Routine chromosome / karyotype + AneuVysion FISH (13/18/21/X/Y) (88235, 88269, 88280, 88285, 88271x5, 88274)	<input type="checkbox"/> DiGeorge/VCF 22q11 <input type="checkbox"/> SRY Yp
<input type="checkbox"/> Routine chromosome / karyotype + specific FISH → → → →	<input type="checkbox"/> STS Xp22.3 <input type="checkbox"/> KAL Xp
<input type="checkbox"/> Culture and freeze cells	<input type="checkbox"/> Angelman 15q12
	<input type="checkbox"/> Miller Dieker 17p13 <input type="checkbox"/> other _____
<input type="checkbox"/> AF-AFP <input type="checkbox"/> AchE <input type="checkbox"/> Fetal Rh { } c { } D { } E	<input type="checkbox"/> DNA testing: _____
<input type="checkbox"/> Hold cells per physician <input type="checkbox"/> Special/Specify _____	

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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:**  Amniotic Fluid  CVS  PUBS

**Fluid appearance:**  clear  cloudy  bloody  brown  green  clotted

**Amount of fluid:** \_\_\_\_\_ mls **Size of pellet:**  tiny  small  medium  large

**Number of Tubes:**  1  2  3  4

**Additional Specimen Evaluation:** \_\_\_\_\_

**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: \_\_\_\_\_

AF on GEL

**Additional Studies / Results:**  NOR  C-band  R-band

**FISH:**  normal male  normal female  
 abnormal  +13  +18  +21  +/-X/Y  Other: \_\_\_\_\_

**To:** \_\_\_\_\_ **By:** \_\_\_\_\_ **Date** \_\_\_\_\_