

2016 **MOLECULAR GENETICS FORM FOR DNA ANALYSIS** 2016

Medical Genetics – Wake Forest University Medical Center – Winston Salem NC  
 Phone: 336-716-4321 Fax: 336-716-2554 Web: www.wakehealth.edu/medicalgenetics/

**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:** \_\_\_\_\_ **Patient's Mother's first name:** \_\_\_\_\_ **Hospital Unit #:** \_\_\_\_\_

**Type of Specimen:**  Blood  Bone Marrow  Amniotic Fluid  Tissue  Cheek Swab  Paraffin Block  DNA

**Collection Technique:** 5 to 10cc of blood collected in a purple top EDTA tube – room temperature  
 (Microarray testing also requires 5 to 10cc of blood collected in a green top Sodium Heparin tube)

Physician/Provider Order		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		
3		
		<b>Patient Signature:</b> _____ <b>Date:</b> _____

**Billing Information**

**Bill:**  Forsyth Novant  Moses Cone Clinical Lab  CFMFC  Women's Hospt Greensboro Clinical Lab  
 Other : \_\_\_\_\_  
 Medicare # \_\_\_\_\_  Medicaid #: \_\_\_\_\_  Carolina Access #: \_\_\_\_\_  
 Insurance: \_\_\_\_\_ Employer: \_\_\_\_\_ Policy #: \_\_\_\_\_  
 (Enclose copy of both sides of insurance card)

**SIGNS/SYMPTOMS/INDICATION (ICD-10 CODES) FOR A DNA STUDY**

Indicate **all** that apply. Codes here do not represent entire listing of ICD-10 codes available. Please consult current ICD-10 code book for complete listing.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> ADHD (F90.2)                        | <input type="checkbox"/> developmental delay (F88)          | <input type="checkbox"/> learning delay (F81.9)             |
| <input type="checkbox"/> AML (C92.00)                        | <input type="checkbox"/> failure to thrive, child (R62.51)  | <input type="checkbox"/> mod. intellectual disability (F71) |
| <input type="checkbox"/> AML in remission (C92.01)           | <input type="checkbox"/> failure to thrive, newborn (P92.6) | <input type="checkbox"/> mult congenital anomalies(Q89.7)   |
| <input type="checkbox"/> AML in relapse (C92.02)             | <input type="checkbox"/> hypotonia, cong (P94.2)            | <input type="checkbox"/> obesity unspec (E66.9)             |
| <input type="checkbox"/> autism – infantile (F84.0)          | <input type="checkbox"/> lack of coordination (R27.8)       | <input type="checkbox"/> short stature (R62.52)             |
| <input type="checkbox"/> cystic fibrosis screening (Z13.228) | <input type="checkbox"/> language delay (F80.9)             | <input type="checkbox"/> transplant status, BM (Z94.81)     |
- Additional Clinical Information/ICD-10 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.)

**TEST(S) REQUESTED**

- |  |   |
|--|---|
| <input type="checkbox"/> Angelman Syndrome (SNRPN Methylation)                     | <input type="checkbox"/> Maternal Cell Contamination Genotyping                       |
| <input type="checkbox"/> Chimerism Genotyping { } Pre- or { } Post-Transplantation | <input type="checkbox"/> Microarray { } Patient or { } Parent { } Prenatal { } Cancer |
| <input type="checkbox"/> Cystic Fibrosis (CFTR)                                    | <input type="checkbox"/> Myotonic Dystrophy (DMPK)                                    |
| { } Carrier Screen or { } Genotype   | <input type="checkbox"/> Prader-Willi Syndrome (SNRPN Methylation)                    |
| <input type="checkbox"/> DNA Banking, Extraction and/or Sendout                    | <input type="checkbox"/> Premature Ovarian Failure (FMRI)                             |
| <input type="checkbox"/> Fragile X-associated Tremor/Ataxia Syndrome (FMRI)        | <input type="checkbox"/> Zygosity Genotyping  |
| <input type="checkbox"/> Fragile X Syndrome (FMRI)                                 | <b>Please call for CPT codes for specific tests</b>                                   |

**Ethnic Background (Important for accurate Cystic Fibrosis test interpretation):**

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> NW European Caucasian    | <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Hispanic         | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> S European Caucasian     | <input type="checkbox"/> Other Jewish     | <input type="checkbox"/> African American |                                       |
| <input type="checkbox"/> Mixed European Caucasian | <input type="checkbox"/> Asian            | <input type="checkbox"/> Native American  |                                       |

**Symptomatic Individuals:** Check most appropriate box:  Possible Dx  Definite Dx

**Asymptomatic Individuals:** (Carrier/Predictive Testing) Check most appropriate box:  
 Previous Affected Child\*  Pregnancy at Risk\*  Family History\*  Carrier Screen

\*Please include pedigree