2017 MOLECULAR GENETICS FORM FOR DNA ANALYSIS 2017

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

Physician: 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 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.

☐ ADHD (F90.2)
☐ AML (C92.00)
☐ AML in remission (C92.01)
☐ AML in relapse (C92.02)
☐ autism – infantile (F84.0)
☐ cystic fibrosis screening (Z13.228)
☐ developmental delay (F88)
☐ failure to thrive, child (R62.51)
☐ failure to thrive, newborn (P92.6)
☐ hypotonia, cong (P94.2)
☐ lack of coordination (R27.8)
☐ language delay (F80.9)
☐ learning delay (F81.9)
☐ mod. intellectual disability (F71)
☐ mult congenital anomalies(Q89.7)
☐ obesity unspec (E66.9)
☐ short stature (R62.52)
☐ 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

☐ Angelman Syndrome (*SNRPN* Methylation)
☐ Chimerism Genotyping { } Pre- or { } Post-Transplantation
☐ Cystic Fibrosis (*CFTR*)
{ } 64 Variant Carrier Screen or { } Full Gene Sequencing
☐ DNA Banking, Extraction and/or Sendout
☐ Fragile X-associated Tremor/Ataxia Syndrome (*FMR1*)
☐ Fragile X Syndrome (*FMR1*)
☐ Maternal Cell Contamination Genotyping
☐ Microarray { } Patient or { } Parent { } Prenatal { } Cancer
☐ NGS Panels { } Epilepsy { } Epilepsy reflex { } Ciliopathy
{ } Hypertrophic Cardiomyopathy
{ } Non-syndromic Hearing Loss
☐ Prader-Willi Syndrome (*SNRPN* Methylation)
☐ Premature Ovarian Failure (*FMR1)*
☐ Zygosity Genotyping
Please call for CPT codes for specific tests

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

☐ NW European Caucasian ☐ Ashkenazi Jewish ☐ Hispanic ☐ Other:_____
☐ S European Caucasian ☐ Other Jewish ☐ African American
☐ Mixed European Caucasian ☐ Asian ☐ 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