Physician Request for Additional Cytogenetic Testing

Physician: ___________________________ Date: ______________________

Patient: ___________________________ Lab Number: __________________

Test requested: ___________________________ Date: ______________________

Preliminary cytogenetic results and/or requests from the referring physician(s), it is recommended that additional cytogenetic testing be performed to complete the analysis. The recommended test(s) are:

CPT code

[ ] 88233 Tissue culture and processing of cells for send-out testing

[ ] 88240 Cryopreservation, freezing and storage of cells, each cells line

[ ] 88241 Thawing and expansion of frozen cells, each aliquot

[ ] 88261 Chromosome analysis; count 5 cells, 1 karyotype, with banding

[ ] 88262 Count 15-20 cells, 2 karyotypes, with banding

[ ] 88263 Count 45 cells for mosaicism, 2 karyotypes, with banding

[ ] 88280 Chromosome analysis; additional karyotypes, each analysis

[ ] 88283 Additional specialized banding technique (eg, NOR, C-banding)

[ ] 88285 Additional cells counted, each study

[ ] 88289 Additional High resolution study

[ ] Other: ____________________________________________________________

Upon your approval, we will proceed with the necessary testing

Physician approval signature: ___________________________ Date: ______

Verbal approval by: ___________________________ Date: ______

Laboratory Director/Supervisor: ___________________________ Date: ______

Please FAX your reply to 336-716-2554 asap (within 1 week of the above date)

If you have any questions please call 336-716-4321 Thank you for your assistance.