Integrated GENETICS
LabCorp Specialty Testing Group

POSTNATAL TEST REQUISITION

Highlighted fields are required.

Patient Information

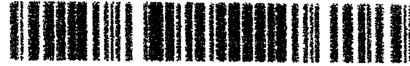
Name ______ Last ______ First ______ MI
☐ Male ☐ Female Date of Birth / /

Address ______
Home Phone ______ Work Phone ______

City ______ State ______ Zip ______
Lab # ______ Hospital # ______

Client Information

482963-482964
St. Luke's Hospital of KC
4400 Wornall Road
B Level
Kansas City, MO 64111



I have obtained informed consent of the patient (or the patient's authorized representative) for the ordered genetic test(s) in accordance with applicable law.

Physician/Authorized Signature: ______

NPI#: ______ Taxonomy#: ______

Referring Physician (print): ______

Genetic Counselor (print): ______

Refer to www.integratedgenetics.com to access informed consent forms for genetic testing.

Collection date: / / Date sent: / / Collected by: ______

Specimen Type (Check one) ☐ Peripheral Blood ☐ Skin Biopsy ☐ Cord Blood
☐ POC/Fetal Tissue (GA wks _____ tissue origin ___________ fetal sex if known ______)
☐ Blood Spot Card ☐ Mouthwash ☐ Buccal swab ☐ Other ______

Laboratory Test(s) Ordered

See back ☐ Chromosome Analysis
See back ☐ If chromosomes are normal, reflex to Reveal® SNP Microarray
478 ☐ If POC/tissue fails to grow, reflex to Reveal® SNP Microarray – POC*
162 ☐ Chromosome analysis with Mosaicism study
See back ☐ Abbreviated Chromosome Analysis & Reveal® SNP Microarray‡
See back ☐ Reveal® SNP Microarray
☐ Parental follow up to abnormal microarray (additional charges may apply)
Test code on original report: ______
(Attach copy of original report or name and DOB of patient previously tested)
140 ☐ DEB Breakage Study (routine chromosome analysis included)

FISH
105 ☐ InSight® (FISH for 13, 18, 21, X and Y)
286 ☐ Angelman
287 ☐ Cri-Du-Chat
287 ☐ DiGeorge/VCF
287 ☐ Kallmann
287 ☐ Miller-Dieker
286 ☐ Prader-Willi
287 ☐ Smith-Magenis
287 ☐ Steroid Sulfatase Deficiency
287 ☐ Williams
287 ☐ Wolf-Hirschhorn
☐ Other FISH – specify ______

Single Gene Disorders
521 ☐ Fragile X, PCR & Southern **#
530 ☐ CF*plus*® (97 mutation test)
582 ☐ If CF*plus*® is not positive for 2 mutations, reflex to full sequencing
538 ☐ Poly(T) Testing for CFTR Intron 8
Cystic Fibrosis (CFTR): 451910 ☐ Gene-specific Sequencing ☐ 451382 Mutation-specific Sequencing
Mutation(s) ______
565 ☐ Angelman Syndrome Methylation Analysis
565 ☐ Prader-Willi Methylation Analysis
☐ **Other testing** – specify (call before sending) ______

*To provide testing on patients from New York state, routine cytogenetics must also be performed.
☐ NY clients check here to indicate this has been done.
Not currently NY state approved.
** Maternal cell contamination analysis required for all prenatal dx (send a maternal sample).
# Dx test for prenatal samples/symptomatic/family history

Indication(s) for Test (check all that apply)

All diagnoses should be provided by the ordering physician or an authorized designee.
Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required)

ICD-CM		ICD-CM		ICD-CM	

If ordering Reveal® SNP Microarray please submit Clinical Questionnaire

☐ Family history of (include report where applicable):
☐ Chromosome abnormality – specify ______
Specify relationship of affected individual ______
☐ ID/DD
☐ Autism/Autism spectrum disorders
☐ Birth defects (specify) ______
☐ Other (specify) ______
☐ Parent has chromosome rearrangement/mosaicism–specify ______
☐ Multiple congenital anomalies
☐ CNS ______
☐ Facial dysmorphism ______
☐ Heart ______
☐ Genitourinary ______
☐ Growth/skeletal ______
☐ Eye/skin ______
☐ Other ______
☐ Clinical features of chromosome abnormality – specify ______
☐ Failure to thrive ☐ Child ☐ Newborn
☐ Developmental delay
☐ Cognitive ☐ Gross motor ☐ Fine motor ☐ Growth
☐ Intellectual disability (ID)
☐ Mild ☐ Moderate ☐ Severe ☐ Profound
☐ Autism/Autism spectrum disorders
☐ Parental chromosome analysis following abnormal postnatal results
Specify ______
☐ Clarify abnormal chromosomes – provide results and a copy of the karyotype
☐ Fetal loss/Stillbirth (POC) ☐ <20 wks ☐ >20 wks
☐ Multiple SABs (spontaneous abortion)
☐ Identification of complete or partial mole (POC)
☐ Other infertility ______
☐ Other: ______

BILLING INFORMATION

Patient Hospital Status: ☐ Inpatient ☐ Outpatient ☐ Non-hospital
☐ Medicaid ☐ Medicare ☐ Insurance ☐ Client Bill ☐ CA XAFP ☐ Self-Pay
☐ Billing Information Attached (Please include a copy of insurance card or face sheet.)
Do not attach credit card information to this form for security purposes.
Insurance Company Name ______
Policy # ______ Group # ______
Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______
Patient Signature ______

INTEGRATED GENETICS INTERNAL USE ONLY

By signing this form, I hereby authorize Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to LCAH.
I understand that I am responsible for any amounts not paid by insurance for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.