



CLIENT INFORMATION		ORDERING PHYSICIAN INFORMATION			
		Ordering Provider		Copy To Provider	
		NPI		NPI	
Tel	Fax	Tel	Fax	Tel	Fax
PATIENT INFORMATION					
Name (Last, First, MI)		SSN	DOB / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Client Patient ID		Address (City, State, Zip)			
		Tel			
BILLING INFORMATION					
<input type="checkbox"/> Facility <input type="checkbox"/> Insurance <input type="checkbox"/> Patient		Insurance Company		Policy #	Group #
Place of Service <input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Physician Office		(Attach copy of Insurance info)			
CLINICAL AND SPECIMEN INFORMATION					
Ethnic Background <input type="checkbox"/> African American <input type="checkbox"/> Ashkenazic Jewish <input type="checkbox"/> Other Jewish		Indication for Molecular Study / History		<input type="checkbox"/> Known Familial Mutation / Variant Analysis	
<input type="checkbox"/> Asian <input type="checkbox"/> European Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American Indian		<input type="checkbox"/> Asymptomatic/population screening		_____	
<input type="checkbox"/> Other (Please Specify) _____		<input type="checkbox"/> Asymptomatic / Positive Family History		_____	
Diagnosis Codes _____		Specimen Source		Specimen ID	
<input type="checkbox"/> Pathology report included					
Clinical Diagnosis/Reason for Referral		<input type="checkbox"/> POC: Tissue type _____			
		<input type="checkbox"/> Fetal Blood <input type="checkbox"/> PUBS (Cord Blood) <input type="checkbox"/> Peripheral Blood			
Collection Date/Time / / _____ <input type="checkbox"/> am <input type="checkbox"/> pm		EGA _____ wks _____ days			
CYTOGENETIC TESTS		MOLECULAR GENETIC TESTS (must include patient consent form)			
<input type="checkbox"/> CYTO POC Chromosome Analysis Products of Conception		<input type="checkbox"/> M CF 39 Cystic Fibrosis illumina xTAG 39 Assay			
<input type="checkbox"/> CYTO PB Chromosome Analysis Peripheral Blood		<input type="checkbox"/> M CF NGS 139 Cystic Fibrosis MiSeqDx 139 Variant Assay by NGS			
		<input type="checkbox"/> M CF NGS SEQ Cystic Fibrosis MiSeqDx Clinical Sequencing Assay by NGS			
FISH TESTS		COMMENTS			
<input type="checkbox"/> F ANEU Aneuploidy: [+13,+18,+21, X,Y]					
<input type="checkbox"/> F AS* Angelman Syndrome					
<input type="checkbox"/> F Del5p* Cri-du-Chat/SOTOS Syndrome					
<input type="checkbox"/> F VCF* DiGeorge/Velo-Cardio-Facial Syndrome					
<input type="checkbox"/> F KAL* Kallmann Syndrome					
<input type="checkbox"/> F LIS* Miller-Dieker Syndrome/Lissencephaly					
<input type="checkbox"/> F PMS* Phelan-McDermid Syndrome					
<input type="checkbox"/> F PWS* Prader-Willi Syndrome					
<input type="checkbox"/> F SMS* Smith-Magenis Syndrome					
<input type="checkbox"/> F SRY* SRY / X Centromere					
<input type="checkbox"/> F STS* Steroid Sulfatase Deficiency					
<input type="checkbox"/> F T21* Trisomy 21					
<input type="checkbox"/> F WIL* Williams Syndrome					
<input type="checkbox"/> F WH* Wolf-Hirschhorn Syndrome					
*performed by affiliate lab					