313.916.4DNA (4362)
Toll Free: 855.916.4DNA
Fax: 313.916.7071
www.henryford.com/hfcpd

HENRY FORD CENTER FOR PRECISION DIAGNOSTICS

Ship specimens to:
Henry Ford Center for Precision Diagnostics
Henry Ford Hospital
Pathology and Laboratory Medicine
Clinic Building, K6, Core Lab, E-655
2799 W. Grand Blvd. | Detroit, MI 48202

FETAL AND GENERAL CYTOGENETIC REQUEST FOR CHROMOSOME/FISH/MICROARRAY TESTING

USE ONE FORM PER EACH SPECIMEN TYPE

Required Patient Information

Name: _____ Gender: M F

MRN: _____ DOB: MM / DD / YY

Insurance Authorization #: _____

ICD-10 Codes are required for billing. When ordering tests for which reimbursement will be sought, order only those tests that are medically necessary for the diagnosis and treatment of the patient.

ICD10 Code(s): _____ / _____ / _____

Ordering Physician Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Specimen Collection Date: _____

Clinical Diagnosis: _____

This request to order tests from HFCPD certifies to HFCPD that (1) the ordering physician has obtained written informed consent from the patient as required by applicable state or federal laws for each test ordered and (2) the ordering physician has authorization from the patient permitting HFCPD to report results for each test ordered to the ordering physician.

The tests below may include microdissection and/or reflex testing at a separate additional charge. All tests include pathologist interpretation at a separate additional charge.

General Genetic Analysis

Indication for Genetic Testing (check all that apply):

- ❑ Birth defects (please describe): _____
- ❑ Development delay
- ❑ Dysmorphic features (please describe) _____
- ❑ Family history of (name disorder): _____
- ❑ Hypotonia
- ❑ Infertility
- ❑ R/O Turner Syndrome
- ❑ Primary amenorrhea
- ❑ History of pregnancy loss: Gr _____ Para _____ Ab _____
- ❑ Diagnostic testing
- ❑ Symptomatic
- ❑ Other: _____

Pedigree or clinical history: _____

Specimen Type: transport specimens at room temperature

- ❑ Peripheral blood (10 ml in sodium heparin; 3 ml for infants; plus 1 EDTA tube if ordering Microarray)
- ❑ Skin biopsy (send in sterile media, Ringer's lactate or saline) (DO NOT USE IODINE TO CLEAN AREA)
- ❑ Products of conception; tissue source: _____ (send in sterile media, Ringer's lactate or saline)
  - ❑ Maternal Cell Contamination (MCC) (CPT 81265) (submit maternal EDTA blood sample with all products of conception)
- ❑ Other: _____

Test Requested

- ❑ Microarray (Array-CGH), (CPT 81229)
  - ❑ reflex to chromosome analysis if normal (use CPT codes below)
- ❑ Chromosome analysis (CPT 88261, 88280, 88285, 88230, 88291)
  - ❑ High resolution chromosome analysis (CPT codes listed for "Chromosome analysis + 88289)
- ❑ **Fluorescent in situ hybridization (FISH):** (CPT 88271x2, 88275, 88273)
  - ❑ DiGeorge/VCFS (22q11.2)
  - ❑ Ichthyosis, X-Linked (Xp22.3)
  - ❑ Other (specify): _____

*FISH for specific deletion syndromes is available.
Check 'Other' and specify or call lab (1.855.916.4DNA) to make arrangements.

Fetal Analysis

Indication for Fetal Genetic Testing (check all that apply)

- ❑ Maternal Age
- ❑ Abnormality on u/s (specify): _____
- ❑ Family History (specify): _____
- ❑ Other: _____
- ❑ NIPT positive for: ❑ + 21 ❑ + 18 ❑ + 13
  - ❑ Other: _____

Specimen Type:

- ❑ Amniotic fluid (15-20 ml of fluid in 2-3 aliquots), Fluid Color: _____
- ❑ Chorionic Villus

Required Information:
Pregnancy History
Maternal Age: _____
Gr _____ Para _____ Ab _____
Gestational age: _____ weeks
LMP: _____ EDC: _____ BPD or other: _____ mm
Date u/s procedure performed: _____

Test Requested:

❑ Check if parents do not wish to learn sex of the fetus.

- ❑ Chromosome analysis (CPT 88261, 88280, 88285, 88233, 88235, 88291)
  - ❑ Alpha fetoprotein ❑ ACHE
  - Special testing: ❑ Toxoplasmosis (maternal serum required)
  - ❑ CMV ❑ Other (specify): _____
- ❑ FISH, Aneuploidy (CPT 88271x5, 88274x2) (requires an additional 5 ml of fluid)
- ❑ Reflex Microarray (CPT 81229) CGH (if normal chromosome analysis)
- ❑ Direct Microarray (CPT 81229) CGH (requires an additional 15 ml of amniotic fluid)
- ❑ Additional testing (specify): _____

*NOTE: Any special testing may require Maternal Cell Contamination - submit maternal EDTA blood sample.

Send Additional Report To (Name):

Address:

Phone Number: Fax Number:

Lab Use ONLY: