

| | | | |
|-------------------------|------------------|-------------------------|-------|
| For Lab Use Only | Facility Name | Ordering Physician Name | |
| | Address | Last | First |
| | City, State, Zip | Physician NPI No. | |
| | Phone () | Report to Fax () | |

| | | | |
|---|--|---|----------------------------------|
| Patient Name - Required (Last) (First) | | Billing Info <input type="checkbox"/> Copy of Front & Back of Ins. Card Attached | |
| Location Unique Identifier or MRN | | <input type="checkbox"/> Private Ins./PPO <input type="checkbox"/> Medicare <input type="checkbox"/> Inpatient <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Client <input type="checkbox"/> Outpatient | |
| CSN - | DOB - Required | Sex | Responsible Party (Please Print) |
| Patient's Phone Number () | Collection Date & Time - Required | Collected By - Required | Street Address |
| Copy to: First Name Last Name | | City, State, Zip | |
| Address: | | Ph. () | |
| | | Fax () | |
| ICD9 Code(s) - REQUIRED INFORMATION | | | |

Each individual test and CMS approved panel must have ICD-9 code(s) to indicate the medical necessity of the test requested. Please document **all** applicable ICD-9 codes for the tests ordered. Tests for medicare patients must be screened to determine if an Advanced Beneficiary Notice (ABN) is required. An ABN should be provided to the patient if there is a reason to believe Medicare will not pay for the test. Medicare may deny tests due to frequency. Medicare does not generally cover routine screening tests.

Clinical Indication / History:

LMP _____ Gravida _____ Para _____ Sample Type: _____

Gest. Age _____ SAB _____ TAB _____ Clinical Hx: _____

CHROMOSOME STUDIES (Misys Code: CYTGEN)

| | | | |
|--|-------------------|--|---------------------|
| <input type="checkbox"/> Amniotic Fluid, Chromosome Analysis | CG AMINO | <input type="checkbox"/> Tissue, Chromosome Analysis (Prod. of concept.) | CG TISS POC |
| <input type="checkbox"/> Chorionic Villi, Chromosome Analysis | CG CVS | <input type="checkbox"/> Tissue Chromosome Analysis (skin/other tissue) | CG TISS SKIN |
| <input type="checkbox"/> Blood, Chromosome Analysis (Routine) | CG BLOOD | Tissue Type: _____ | |
| <input type="checkbox"/> Blood, High Resolution, Chromosome Analysis | CG HI RES | | |
| <input type="checkbox"/> Blood, Breakage Analysis, Fanconi Anemia | CG FANCONI | <input type="checkbox"/> Tissue Culture, Reference Test | CG TISS REF |
| <input type="checkbox"/> Blood, Breakage Analysis, Ataxia Telangiectasia | CG ATAXIA | Reference Lab/Test (referral paperwork must be provided) | |

FISH (Misys Code: CYTGEN)

| | | | | | |
|---|---------|-------------------|--|---------|------------------|
| <input type="checkbox"/> Angelman Syndrome | 15q11.2 | CGF ANGLM | <input type="checkbox"/> Smith-Magenis Syndrome | 17p11.2 | CGF SMS |
| <input type="checkbox"/> Cri du Chat Syndrome | 5p15.2 | CGF MCDEL | <input type="checkbox"/> Williams Syndrome | 7q11.2 | CGF WMS |
| <input type="checkbox"/> DiGeorge/Velocardiofacial Syndrome | 22q11.2 | CGF VCF | <input type="checkbox"/> Wolf-Hirschhorn Syndrome | 4p16.3 | CGF MCDEL |
| <input type="checkbox"/> Miller-Dieker Syndrome | 17p13 | CGF MDK | <input type="checkbox"/> X-linked Ichthyosis (STS) | Xp22.3 | CGF MCDEL |
| <input type="checkbox"/> Prenatal Screen, FISH for trisomies 13, 18 and 21, X & Y chromosomes | | CGF PRENAT | | | |
| <input type="checkbox"/> Prader-Willi Syndrome | 15q11.2 | CGF PWS | | | |
| <input type="checkbox"/> Other Unique Sequence Probes: _____ | | | | | CGF MAR |

(Call lab at (650) 725-6393 for information)

MOLECULAR GENETICS

| | | | |
|--|--------------------------------|---|-----------------|
| <input type="checkbox"/> Achondroplasia / Hypochondroplasia | CHON / FCHON | <input type="checkbox"/> Factor V Leiden | LEID |
| <input type="checkbox"/> Alpha Thalassemia/Hb Constant Spring | ATHAL / FATHAL / TATHAL | <input type="checkbox"/> FGFR1 Craniosynostosis | FGFR1 |
| <input type="checkbox"/> Ashkenazi Jewish Panel | ASH1 | <input type="checkbox"/> FGFR2 Craniosynostosis | FGFR2 |
| <input type="checkbox"/> Ashkenazi Jewish Panel Extended | ASHEXT | <input type="checkbox"/> FGFR3 Muenke | FGFR3 |
| <input type="checkbox"/> Beta Thalassemia Sequencing | BTHSQ / FBTHSQ | <input type="checkbox"/> Fragile X, DNA | FRAGX |
| <input type="checkbox"/> Connexin 26, Sequencing | CX26S / FCX26S | <input type="checkbox"/> Maternal Cell Contamination | MCC/TMCC |
| <input type="checkbox"/> Connexin 30 | CX30 | <i>Maternal Whole Blood Required with Prenatal Sample Submission</i> | |
| <input type="checkbox"/> CF 32, Cystic Fibrosis, DNA | CF32 / NCF32 | <i>(ALERT: Back-up Culture Required)</i> | |
| <input type="checkbox"/> CF Poly-T Analysis | CFPT | <input type="checkbox"/> Methylene-tetrahydrofolate Reductase (MTHFR) | MTHFR |
| <input type="checkbox"/> Duchenne and Becker Muscular Dystrophy, DNA | DBMD | <input type="checkbox"/> Pendred Syndrome | PDS |
| <input type="checkbox"/> Factor II, Prothrombin-20210A Mutation | P20210 | <input type="checkbox"/> Prader-Willi Syndrome (PWS), RNA | PWS |

OTHER TESTS

For specimen collection questions you may call the testing laboratory at the phone number listed next to the department name or contact our Customer Service department at 1-877-717-3733.

| Chromosome Analysis | | Lab Phone Number: (650) 725-6396 |
|---|--|---|
| Blood | <ul style="list-style-type: none"> 4mL Whole Blood Green-top (sodium heparin) tube Maintain specimen at room temperature | |
| Fluid | <ul style="list-style-type: none"> 20 - 30 mL Amniotic Fluid - Sterile container Provide multiple aliquots (Two 15mL aliquots) Maintain specimen at room temperature | |
| Tissue | <ul style="list-style-type: none"> 0.5-1 cm³ tissue biopsy Sterile tube containing RPMI cell culture media, Sterile saline acceptable if media unavailable Maintain specimen at room temperature | |
| Molecular Pathology | | Lab Phone Number: (650) 723-6574 |
| Blood | <ul style="list-style-type: none"> 4mL Whole Blood Lavender-top (EDTA) tubes Consult Lab Guide for Specimen Handling :RNA Studies –ship on wet ice, DNA Studies ship at room temperature | |
| Tissue | <ul style="list-style-type: none"> 0.5-1 cm³ tissue biopsy Frozen Tissue -maintain frozen and send on dry ice Fresh Tissue -Send sterile tube containing RPMI cell culture media | |
| Fluid | <ul style="list-style-type: none"> Volume varies, contact laboratory Sterile tube Maintain specimen at room temperature | |
| Fluorescence in situ hybridization (FISH) | | Lab Phone Number: (650) 725-6396 |
| Blood | <ul style="list-style-type: none"> 4mL Whole Blood Green-top (sodium heparin) tube Maintain specimen at room temperature | |
| Fluid | <ul style="list-style-type: none"> 20 - 30 mL Amniotic Fluid - Sterile container Provide multiple aliquots (Two 15mL aliquots) Maintain specimen at room temperature | |
| Chromosome Analysis and FISH testing can be performed from a single patient sample if volume is adequate. | | |
| SHIP TO: Stanford's Anatomic Pathology and Clinical Laboratory Attn: Specimen Processing 3375 Hillview Avenue Palo Alto, CA 94304 Phone: 1 (877) 717-3733 | | If shipping Friday check for Saturday delivery Fax delivery notification to: (650) 724-4758 |
| Shipper's Responsibility: The shipper is required to comply with the rules and guidelines for transport of medical specimens as set forth by the United States government, the government of the country of origin and international regulatory agencies. Failure to follow instructions for packaging and shipping specimens can result in the delay, loss or destruction of your specimens. Stanford University Medical Center Clinical Laboratories will not be held responsible for any liability attributable to the shipper's improper actions or failure to comply with regulations. | | |