BAYLOR GENETICS

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
GRAND BLVD. RECEIVING DOCK
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

CYTOGENETICS - PRODUCTS OF CONCEPTION REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY)

Address | City | State | Zip | Phone

Accession # | Hospital / Medical Record #

Patient discharged from the hospital/facility: ◯ Yes ◯ No

Biological Sex: ◯ Female ◯ Male ◯ Unknown

Gender identity (if different from above):

REPORTING RECIPIENTS

Ordering Physician | Institution Name

Email (Required for International Clients) | Phone | Fax

ADDITIONAL RECIPIENTS

Name | Email | Fax

Name | Email | Fax

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

◯ **SELF PAYMENT**

☐ Pay With Sample ☐ Bill To Patient

◯ **INSTITUTIONAL BILLING**

Institution Name | Institution Code | Institution Contact Name | Institution Phone | Institution Contact Email

◯ **INSURANCE**

☐ Do Not Perform Test Until Patient is Aware of Out-Of-Pocket Costs (excludes prenatal testing)

REQUIRED ITEMS 1. Copy of the Front/Back of Insurance Card(s) 2. ICD10 Diagnosis Code(s) 3. Name of Ordering Physician 4. Insured Signature of Authorization

Name of Insured | Insured Date of Birth (MM / DD / YYYY)

Patient's Relationship to Insured | Phone of Insured

Address of Insured

City | State | Zip

Primary Insurance Co. Name | Primary Insurance Co. Phone

Primary Member Policy # | Primary Member Group #

Name of Insured | Insured Date of Birth (MM / DD / YYYY)

Patient's Relationship to Insured | Phone of Insured

Address of Insured

City | State | Zip

Secondary Insurance Co. Name | Secondary Insurance Co. Phone

Secondary Member Policy # | Secondary Member Group #

By signing below, I hereby authorize Baylor Genetics to provide my insurance carrier any information necessary, including test results, for processing my insurance claim. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates, as well as any amounts not paid by my insurance carrier for reasons including, but not limited to, non-covered and non-authorized services. I understand that I am responsible for sending Baylor Genetics any and all payments that I receive directly from my insurance company in payment for this test. Please note that Medicare does not cover routine screening tests.

Patient's Printed Name | Patient's Signature | Date (MM / DD / YYYY)

STATEMENT OF MEDICAL NECESSITY (REQUIRED)

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Physician's Printed Name | Physician's Signature | Date (MM / DD / YYYY)

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Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY) | Biological Sex

ETHNICITY

- ◯ African American
- ◯ Ashkenazi Jewish
- ◯ East Asian (China, Japan, Korea)
- ◯ Finnish
- ◯ French Canadian
- ◯ Hispanic American
- ◯ Mennonite
- ◯ Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey)
- ◯ Native American
- ◯ Northern European Caucasian (Scandinavian, UK, Germany)
- ◯ Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia)
- ◯ South Asian (India, Pakistan)
- ◯ Southeast Asian (Vietnam, Cambodia, Thailand)
- ◯ Southern European Caucasian (Spain, Italy, Greece)
- ◯ Other (Specify): _____

INDICATION FOR TESTING (REQUIRED)

- ☐ Recurrent Pregnancy Loss (N96)
- ☐ Maternal Care for Intrauterine Death, Not Applicable or Unspecified (O36.4XX0)
- ☐ Encounter for Elective Termination of Pregnancy (Z33.2)
- ☐ Missed Abortion (O02.1)
- ☐ Blighted Ovum and Nonhydatidiform Mole (O02.0)
- ☐ Other Abnormal Products of Conception (O02.89)
- ☐ Other (Specify ICD-10 code):

GESTATIONAL INFORMATION

Date of Pregnancy Loss: ____ / ____ / ____ (MM / DD / YYYY)

Gestational Age at Loss (weeks): _____

Type of Pregnancy:
- ☐ Singleton Pregnancy
- ☐ Multiple Gestation

Was an Egg Donor Used During This Pregnancy?
- ◯ Yes
- ◯ No

CYTOGENETIC TESTS

☐ **8800** | **CHROMOSOMES (TISSUE)**

SAMPLE TYPE
- ◯ Fresh Tissue
  - ◯ POC
  - ◯ Villi

DATE OF COLLECTION
____ / ____ / ____ (MM / DD / YYYY)

☐ **8639** | **CMA - POC**

SAMPLE TYPE
- ◯ Fresh Tissue
  - ◯ POC
  - ◯ Villi
- ◯ Frozen Tissue
- ◯ Autopsy Material
- ◯ FFPE Slides #: _____
- ◯ FFPE Blocks #: _____

DATE OF COLLECTION
____ / ____ / ____ (MM / DD / YYYY)

☐ Maternal Cell Contamination Studies
(RECOMMENDED For Test Code 8639)

Mother Last Name | Mother First Name | MI

____ / ____ / ____
Date of Birth (MM/DD/YYYY)

☐ Blood Sample (5 cc in EDTA Tube) collected from Biological Mother

NOTE: Fresh tissue samples should be submitted in sterile media whenever possible (see BMGL.com for specific handling instructions).